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ABSTRACT

This document presents testimony from a congressional hearing examining the Child Abuse Prevention, Adoption, and Family Services Act. In response to the General Accounting Office's (GAO's) concerns about the ability of the National Center on Child Abuse and Neglect (NCCAN) to perform its leadership role in identifying, preventing, and treating child abuse and neglect, this hearing was called to determine the progress made by NCCAN in the 9 months since the GAO concerns were raised and to make a recommendation on the length of the reauthorization for NCCAN. Testimonies focus on the NCCAN role; the role of the U.S. Advisory Board on Child Abuse and Neglect; expansion of child abuse, adoption, and family services programs; and child abuse fatalities. Opening statements are included from Representatives Major R. Owens and Donald M. Payne. A statement from Lesley Wimberly, president, National Association of State Vocal Organizations is presented by Representative William F. Goodling. Witnesses providing testimonies include: (1) Wade Horn, commissioner, Administration for Children, Youth, and Families, Department of Health and Human Services; (2) Joseph Delfico, director, Income Security Issues, GAO; (3) Howard Davidson, U.S. Advisory Board on Child Abuse and Neglect; (4) Tom Birch, Legislative Counsel, National Child Abuse Coalition; (5) Michael Durfee, Child Abuse Prevention Unit, Department of Health Services, Los Angeles, California; (6) Mary Margaret Oliver, State Representative, Georgia State Legislature; and (7) Susan Wells, director, Child Maltreatment Fatalities Project, American Bar Association's Center on Children and the Law, Chapel Hill, North Carolina. Prepared statements, letters, and supplemental materials are included. (NB)

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HEARING ON THE CHILD ABUSE PREVENTION, ADOPTION, AND FAMILY SERVICES ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 27, 1992

Serial No. 102–96

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3

CONTENTS

Page

Hearing held in Washington, DC, February 27, 1992 1

Statement of:

Delfico, Joseph, Director, Income Security Issues, General Accounting Office, Washington, DC; Howard Davidson, U.S. Advisory Board on Child Abuse and Neglect, Washington, DC; and Tom Birch, Legislative Counsel, National Child Abuse Coalition, Washington, DC 46

Durfee, Michael, M.D., Child Abuse Prevention Unit, Department of Health Services, Los Angeles, CA; Hon. Mary Margaret Oliver, State Representative, District 53, Georgia State Legislature; accompanied by Hon. Ben Jones, a Representative in Congress From the State of Georgia; and Susan Wells, Ph.D., Director, Child Maltreatment Fatalities Project, ABA Center on Children and the Law, Chapel Hill, NC 116

Horn, Wade, Ph.D., Commissioner, Administration for Children, Youth, and Families, Department of Health and Human Services, Washington, DC; accompanied by Joe Mottola, Deputy Commissioner, Department of Health and Human Services, Washington, DC 16

Wimberly, Lesley D., President, National Association of State Vocal Organizations (NASVO), presented by Hon. William F. Goodling, a Representative in Congress from the State of Pennsylvania 2

Prepared statements, letters, supplemental materials, et cetera:

Ballenger, Hon. Cass, a Representative in Congress from the State of North Carolina, prepared statement of 9

Birch, Tom, Legislative Counsel, National Child Abuse Coalition, Washington, DC, prepared statement of 100

Davidson, Howard, U.S. Advisory Board on Child Abuse and Neglect, Washington, DC, prepared statement of 71

Delfico, Joseph, Director, Income Security Issues, General Accounting Office, Washington, DC, prepared statement of 49

Durfee, Michael, M.D., Child Abuse Prevention Unit, Department of Health Services, Los Angeles, CA, prepared statement of 120

Horn, Wade, Ph.D., Commissioner, Administration for Children, Youth, and Families, Department of Health and Human Services, Washington, DC, prepared statement of 19

Oliver, Hon. Mary Margaret, State Representative, District 53, Georgia State Legislature, prepared statement of 130

Owens, Hon. Major R., a Representative in Congress from the State of New York, prepared statement of 12

Thomas, Joyce N., President, Center for Child Protection and Family Support, Inc., additional statement for the record 261

Wells, Susan, Ph.D., Director, Child Maltreatment Fatalities Project, ABA Center on Children and the Law, Chapel Hill, NC, prepared statement of 245

Wimberly, Lesley D., President, National Association of State Vocal Organizations (NASVO), prepared statement of 6

HEARING ON THE CHILD ABUSE PREVENTION, ADOPTION, AND FAMILY SERVICES ACT

THURSDAY, FEBRUARY 27, 1992

House of Representatives,
Subcommittee on Select Education,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., Room 2257, Rayburn House Office Building, Hon. Major R. Owens, Chairman, presiding.

Members present: Representatives Owens, Payne, Serrano, Ballenger, Klug, Goodling, and Jones.

Staff present: Maria Cuprill, Wanser Green, Laurence Peters, Sylvia Hacaj, Robert MacDonald, Alan Lovesee, and Sally Lovejoy.

Chairman Owens. The Subcommittee on Select Education will come to order.

Today's hearing on the Child Abuse Prevention, Adoption, and Family Services Act will focus on the role of the National Center on Child Abuse and Neglect; the role of the U.S. Advisory Board on Child Abuse and Neglect; expansion of child abuse, adoption, and family services programs; and issues of child abuse fatalities.

The General Accounting Office, in its testimony before the subcommittee on May 9, 1991, raised serious concerns about the ability of the National Center on Child Abuse and Neglect to perform its leadership role in identifying, preventing, and treating child abuse and neglect.

They also questioned the ability of Health and Human Services to manage its grant workload, warning that NCCAN could repeat past administrative failures if concrete steps were not taken to correct shortages in staffing and resources.

Although NCCAN was being reorganized into the new Administration for Children and Families at the time, GAO advised the subcommittee to consider either reducing its expectations for NCCAN or providing other avenues for achieving the goals outlined in the legislation if NCCAN issues and programs were not given priority attention.

Today we want to determine the extent of the progress made by NCCAN over the last 9 months and, based on this assessment, make a recommendation on the length of the reauthorization for this component.

I will return to the issues raised in my opening statement when we resume. At this point, I'd like to yield to Mr. Payne for an opening statement.

Mr. PAYNE. Thank you very much, Mr. Chairman.

Let me commend you for calling this very important hearing this morning to enable our subcommittee to evaluate the progress being made under the Child Abuse Prevention, Adoption, and Family Services Act.

During these difficult economic times, family problems often worsen as a result of increased stress and anxiety. For this reason, it is more important than ever that we emphasize child abuse prevention and early intervention programs.

We know how serious the problem has become. Over the past 10 years, reports of child abuse and neglect have more than doubled. The explosion of illegal drug activities have taken a heavy toll on families, and thousands of children struggle to cope with their parents' drug abuse problems. Unfortunately, a number of newborns now begin life with illegal drugs in their system as a result of their mother's addiction.

As a sponsor of the bill to reauthorize the Abandoned Infants Assistance Act, I am grateful for the support I received from the Chairman of the Select Education Subcommittee and my colleagues in the last session of Congress for this important legislation which aims to prevent the abandonment of infants and to keep families together when it is in the best interests of the child.

Child abuse is a terrible tragedy, but it can be prevented. We need to offer families the support they need to confront the problems that lead to violence and abuse.

Mr. Chairman, I hope this hearing today will help us build on our efforts to give all children the stable and happy future that they deserve.

Chairman OWENS. Thank you, Mr. Payne.

We are pleased to have with us this morning the ranking member of the full Education and Labor Committee, who will lead with his testimony when we resume.

We are going to have to recess for 5 to 7 minutes for a vote.

[Recess.]

Chairman OWENS. The subcommittee will come to order.

Mr. Goodling.

STATEMENT OF LESLEY D. WIMBERLY, PRESIDENT, NATIONAL ASSOCIATION OF STATE VOCAL ORGANIZATIONS (NASVO), PRESENTED BY THE HONORABLE WILLIAM F. GOODLING, REPRESENTATIVE FROM THE STATE OF PENNSYLVANIA

Mr. GOODLING. Thank you, Mr. Chairman. I appreciate your giving me the opportunity to read the testimony.

When I talk about case work in my district, I probably get as many calls on this issue as anything else. Many times it's parents who believe they have been abused. Having been an educator most of my life, I saw this, what I would term, first-hand parent abuse.

So many times what has happened then, the child has really suffered as they were bounced from one agency to the next agency, then to a group home, and then eventually, at the wonderful age of 18, kicked out and left to fend for themselves.

So I think the testimony that I have to read to you is very, very important as part of the hearing material you will study. I have a collage that I will also give to the members from my local newspapers about some of the issues that I will be talking about.

Mr. Chairman, this testimony is from Lesley D. Wimberly, who is a Commissioner for the California Child Welfare Strategic Planning Commission.

"I must first apologize for my not being able to attend this hearing personally. I had prior commitments to a court of law that could not be broken. However, I have sent a representative of our organization in my place to provide your committee members with whatever questions you wish answered—" one of those is from my district "—and so if you have any questions that you want them to answer, they would be available to answer them.

"I have read the agenda list and noticed that those who are appearing before this subcommittee are of disciplines involved with the child protection system. I regret that only NASVO and its VOCAL chapters are represented here by my own testimony, and there appears no other representative of the family unit or the 'clients' of the child protection system.

"It seems inherent in government to look to those who work in the bureaucracy for information regarding specific issues and funding, rather than those who will be most affected by any actions or recourse taken by that bureaucracy.

"I find that unfortunate, for no one can begin to get the whole picture without hearing from all sides of any issue. However, we are here today, and for that, honorable committee members, we thank you."

I noticed in Mr. Payne's opening remarks, he emphasized what I try to emphasize. How can we keep the families together, whenever possible?

"No one can deny that children are abused throughout our country and that, as a responsible people, we are obligated to protect those most vulnerable of our citizens. But while we move to protect this specific population and to promote a government protection over this population, we must take care that in our zeal to protect we do not abuse the innocent. The innocent I speak of are not just the families, but more importantly, the very children we all seek to serve.

"In the early 1980s, child protection was the political issue of the decade. Hurriedly, laws were enacted to (1) mandate reporting, (2) provide immunities to those who report, (3) and provide heavy penalties in the law to punish those who abuse.

"I cannot think of anyone who was against this movement at that time. We failed, however, in our haste to provide the basics of an accountable, professional child protective system.

"We did not provide funding for a training criteria with certification, so that those on the front line of intervention would have the skills, tools, and knowledge with which to handle emergency response with accuracy.

"We did not provide funding to promote intensive family services for those who were impoverished or dysfunctional, which, according to the latest studies, comprises 90 percent of those families in the system.

"We did not treat the child holistically, seeking to find the best remedies for his or her problems. Instead, we ripped them away from the community, their neighborhood and school, and most important, their families. We did not honor the child's cultural or ethnic roots, nor the child's wish to continue connection with those roots.

"Instead, we formed an immense bureaucratic machine that moved as a huge, deaf cyclops, focusing on the report of a child 'at risk' or alleging abuse. Then this cyclops, seeing only its function to 'protect,' stumbles into the fragile world of the child, not hearing its cries, or the cries of the family.

"This huge cyclops also could not see or understand what either his left or right hand was doing, and so a fragmented services system was born. It continues to gorge on billions of taxpayer's dollars, with little going to those who did its bidding at the front end.

"The children are passed from foster home to group home and back again, their parents devastated financially, left without the means to either contact or visit their child; except those lucky few whose visits are by a soda machine at a county office for 1 hour every 2 weeks.

"This well-meaning monster is consuming our families, our government funds, and worst of all, our Nation's children.

"One might even hold such a monstrous device as a well-meaning innocent, except for the fact that the children it holds in its protective grip are not any safer than when they were taken away from home.

"According to a recent study on foster care, child abuse occurs ten (10) times more frequent in foster care than in the child's home. This is because the foster care system is in crisis due to the tremendous numbers of children being placed and remaining in placement, and the 10 percent decrease in foster homes.

"We are stuck with a lower level of qualifications to become a foster parent, no standard of inspection or enough personnel to inspect foster homes, and the result of the high intervention is a rise in the population in each home.

"Overcrowding an unsupervised foster home breeds abuse. Later, these children are 'dumped' out into the streets, with a bus ticket and some money at 18: no family no educational future, no roots, and nowhere to go. States across the Nation are reporting a higher prison population with the majority of inmates coming from the foster and State institutional care homes.

"I cannot believe for an instant that this is what anyone present at this hearing wants for our American children. Certainly not even those who work in the system, and most definitely not those who work in our government. The children and families of this Nation deserve better.

"Recommendations: I understand that this subcommittee may be looking into another approach to protecting at-risk or abused children, and that this may be accomplished through the educational system.

"I strongly advise, that with the deterioration of our present child protection system and the tremendous fiscal burden it has presented State and county governments throughout this Nation, that before entering into another 'Brave New World' or creating policy that will be 'On the Cutting Edge,' that we first deal with the system at hand.

"We need:

"1. The funding encouragement for training academies for emergency response workers. This training will include among other issues, childhood development, questioning techniques, use of electronic recording devices during interviews, cultural sensitivity, and so forth; holding credentials and license, make the workers accountable to their job performance and their clients through our children and families. Without accountability, there can be no professionalism.

"2. The funding encouragement for the establishment of family preservation services, such as Maryland's program, or Georgia PUP, or Washington State's Home Builders. Such programs have been demonstrated to reduce the fiscal responsibility at State and county levels as much as 80 percent. This keeps the child in their family environment, assists dysfunctional or poor families (80 or 90 percent of the entire caseload), and lowers the attrition rate among social workers (they're happier helping than taking children away.)"

Her conclusion: "As a Commissioner for the California Child Welfare Strategic Planning Commission, I have spent hours meeting with those from the inside and outside of the system. We have discussed and re-discussed areas of responsibility and change. There are some solutions, but creating any new area of the present system will achieve only further chaos.

"As the President of VOCAL's national entity, I hope that the members of this subcommittee will take care in their move for further policy regarding families and children. I pray that you all will begin a new policy of listening to the families you are to serve.

"More intervention is not what these families need What they need is a professional and accountable system that assists the child to fulfill its inherent right for a future; that they reach adulthood having experienced a safe, healthy, and nurturing environment.

"The resulting sense of self-worth, coupled with equal access to resources will empower them to develop their unique potential so that they mature realizing a strong sense of responsibility to self, culture, and society.

"To achieve these goals, a child needs a family. To provide that nurturing environment, families need a supportive, accountable system; not division and the loss of their children.

"Thank you for allowing VOCAL's families and children the opportunity to speak today. We pray that we've made a difference."

And I thank you, Mr. Chairman, for the opportunity to read the testimony.

[The prepared statement of Lesley D. Wimberly follows:]

NATIONAL ASSOCIATION OF STATE VOCAL ORGANIZATIONS

VALUING THE AMERICAN FAMILY

UNITED STATES HOUSE OF REPRESENTATIVES
SELECT SUBCOMMITTEE ON EDUCATION

HEARINGS
Thursday, February 27, 1992

TESTIMONY of: The National Association of State VOCAL Organizations (NASVO), Lesley D. Wimberly, Pres.

Post Office Box 1314, Orangevale, Ca 95662
(916)863-7470

INTRODUCTION:

I must first apologize for my not being able to attend this hearing personally. I had prior commitments to a court of law that could not be broken. However, I have sent a representative of our organization in my place to provide your committee members with whatever questions you wish answered.

I have read the agenda list and noticed that those who are appearing before this subcommittee are of the disciplines involved with the child protection system. I regret that only NASVO and it's VOCAL chapters are represented here by my own testimony, and there appears no other representative the family unit or the "clients" of the child protection system. It seems inherent in government to look to those who work in the bureaucracy for information regarding specific issues and funding, rather than those who will be most effected by any actions or recourse taken by that bureaucracy. I find that unfortunate, for no one can begin to get the whole picture without hearing from all sides of any issue. However, we are here today, and for that, honorable committee members, we thank you.

GOVERNMENT INTERVENTION ON BEHALF OF CHILDREN:

No one can deny that children are abused throughout our country, and that as a responsible people, we are obligated to protect those most vulnerable of our citizens. But, while we move to protect this specific population, and to promote a government protection over this population, we must take care that in our zeal to protect we do not abuse the innocent. The innocent I speak of are not just the families, but more importantly, the very children we all seek to serve.

In the early 1980's, child protection was the political issue of the decade. Hurriedly laws were enacted to (1) mandate reporting, (2) provide immunities to those who report, (3) and provided heavy penalties in the law to punish those who abuse. I cannot think of anyone who was against this movement at that time. We failed, however, in our haste to provide the basics of an accountable, professional child protective system.

We did not provide funding for a training criteria with certification, so that those on the front line of intervention would have the skills, tools, and knowledge with which to handle emergency response with accuracy. We did not provide funding to promote intensive family services for those who were impoverished or dysfunctional, which, according to the latest studies, comprises of 90% of those families in the system. We did not treat the child holistically, seeking to find the best remedies for his or her problems. Instead we ripped them away from the community, their neighborhood and school, and most important, their families. We did not honor the child's cultural and ethnic roots, nor the child's wish to continue connection with those roots.

Instead, we formed an immense bureaucratic machine that moved as a huge, deaf, cyclops, focusing on the report of a child "at risk" or alleging abuse. Then this cyclops seeing only it's function to "protect", stumbles into the fragile world of the child, not hearing it's cries, or the cries of the family. This huge cyclops also could not see or understand what either his left or right hand was doing, and so a fragmented services system was born. It continues to gorge on billions of taxpayer's dollars, with little going to those who did it's bidding at the front end[1]. The children are passed from foster home to group home and back again, their parents devastated financially, left without the means to either contact or visit their child. Except those lucky few whose visits are by a soda machine at a county office for one hour every two weeks. This well-meaning monster is consuming our families, our government funds, and worst of all, our nation's children.

One might even hold such a monstrous devise as a well-meaning innocent, except for the fact that the children it holds in it's protective grip are not any safer than when they are taken from home. According a recent study[2] on foster care, child abuse occurs ten (10) times more frequent in foster care than in the child's home. This is because the foster care system is in crisis due to the tremendous numbers of children being placed and remaining in placement, and the ten percent decrease in foster homes. We are stuck with a lower level of qualifications to become a foster parent no standard of inspection or enough personnel to inspect foster homes, and the result of the high intervention, is a rise in the population in each home. Overcrowding an unsupervised foster home breeds abuse. Later, these children are "dumped" out into the streets, with a bus ticket and some money at eighteen: no family, no educational future, no roots, and no where to go. States across the nation are reporting a higher prison population with the majority of inmates coming from the foster and state institutional care homes.

I cannot believe for an instant that this is what anyone present at this hearing wants for our American children. Certainly not even those who work in the system, and most definitely not those who work in our government. The children and families of this nation deserve better.

RECOMMENDATIONS:

I understand that this subcommittee may be looking into another approach to protecting at-risk or abused children, and that this may be accomplished through the educational system. I strongly advise, that with the deterioration of our present child protection system and the tremendous fiscal burden it has presented state and county governments throughout this nation, that before entering into another "Brave New World" or creating policy that will be "On the Cutting Edge" that we first deal with the system at hand.

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[1] In California, the attrition rate among front-line case workers is 60%-80%, depending on the county.

[2] American Civil Liberties Union, Children's Project 1990, Washington, D.C.

We need:

- the funding encouragement for training academies for emergency response workers. This training will include among other issues, childhood development, questioning techniques, use of electronic recording devises during interviews, cultural sensitivity, etc. Holding credentials and license, make the workers ACCOUNTABLE to their job performance and their clients (children and families). Without accountability, there can be no professionalism.
- the funding encouragement for the establishment of family preservation services, such as Maryland's program, or Georgia PUP (Prevent Unnecessary Placement), or Washington state's Home Builders. Such programs have been demonstrated to reduce the fiscal responsibility at state and county levels as much as 80%. This keeps the child in their family environment, assists dysfunctional or poor families (80 - 90% of all caseloads), and lowers the attrition rate among social workers (they're happier helping than taking children away).

CONCLUSION:

As a Commissioner for the California Child Welfare Strategic Planning Commission, I have spent hours meeting with those from the inside and outside of the system. We have discussed, and re-discussed areas of responsibility and change. There are some solutions, but creating any new arm of the present system will achieve only further chaos.

As the President of VOCAL's national entity, I hope that the members of this Sub-Committee will take care in their move for further policy regarding families and children. I pray that you all will begin a new policy of listening to the families you are to serve. More intervention is not what these families need. What we need, is a professional and accountable system that assists the child to fulfill it's inherent right for a future: "that they reach adulthood having experienced a safe, healthy and nurturing environment. The resulting sense of self-worth, coupled equal access to resources, will empower them to develop their unique potentials, so that they mature realizing a strong sense of responsibility to self, culture and society"[1]. To achieve these goals, a child needs a family. To provide that nurturing environment, families need a supportive, accountable system; not devision, and the loss of their children.

Thank you for allowing VOCAL's families and children the opportunity to speak today. We pray that we've made a difference.

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[1] California Child Welfare Strategic Planning Commission. 1992, Sacramento, CA THE VISION.

Chairman **Owens**. Would the distinguished ranking member of the full committee care to take questions?

Mr. **Goodling**. Yes, I would be happy to.

Chairman **Owens**. We've been joined by two additional members of the committee, Mr. Serrano and Mr. Ballenger, the ranking member of this subcommittee.

I yield to Mr. Ballenger for an opening statement and for questions if he would like to make them.

Mr. **Ballenger**. Mr. Chairman, I had an opening statement. It's very short, and if possible, I would just enter it into the record.

[The prepared statement of Hon. Cass Ballenger follows:]

STATEMENT OF HON. CASS BALLENGER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. Chairman, I want to welcome the witnesses here today, especially Dr. Susan Wells, Director of the Child Maltreatment Fatalities Project in Chapel Hill, North Carolina. It is always a pleasure to have experts from my home State testify before this subcommittee and I know that Dr. Wells can provide us with valuable information on ways to reduce the number of child fatalities as a result of child abuse and neglect. She is well recognized in the child protection field and I am looking forward to hearing her views as well as the views of the other witnesses today.

Thank you.

Mr. **Ballenger**. At the present time, I don't really have any questions. I'll pass it back to you.

Chairman **Owens**. Mr. Serrano.

Mr. **Serrano**. Mr. Chairman, I just want to thank you for the opportunity to participate in this hearing, certainly to deal with this very important issue, and to thank the gentleman for coming before us and giving us this testimony.

Chairman **Owens**. Mr. Payne, do you have any questions?

Mr. **Payne**. I agree with many of the statements here. I hope that we can come up with new approaches in attempting to help these young people in need, and look forward to working with the committee to come up with some solution.

Thank you, Mr. Chairman.

Chairman **Owens**. My only comment is that the Child Protection System, which is beyond the jurisdiction of this committee, is blundering, ineffective, and out of control.

We are here to bring attention to this most ineffective system. We are here to try to channel the attention of the decision-makers so that we may get more funds and more effort in the front end of the effort to prevent child abuse.

We want to protect children, but in the process, unless the system is made effective and more efficient, we know it can make blunders and end up hurting families.

In that respect, I think our purposes are the same, once the system is improved and really working effectively. If it gets the kind of high visibility it deserves, and if we have the kind of resources we need, all of these concerns can be taken care of at the same time.

I thank the gentleman for his statements.

Mr. **Goodling**. All the cameras were at the hearing downstairs, Mr. Chairman. I suggested that this hearing may be more important than the math and science hearing downstairs and perhaps they should bring half of the cameras up here, but I noticed none of them came.

Chairman **Owens**. We thank you for your presence. It gives us more visibility. I would like to return to my opening statement and complete it.

The challenges faced by the Nation resulting from the dramatic increase in reported child abuse and neglect as well as family violence, demand that strong leadership also be provided by NCCAN's Advisory Board.

Secretary Louis Sullivan, at the December 6, 1991, National Meeting on Child Abuse and Neglect, told the audience that, "The advisory board has been a catalyst for change on behalf of abused and neglected children."

The advisory board, made up of volunteers, has exceeded our expectations. The two reports they have completed are impressive testaments of the work of an exceptionally dedicated group of public servants.

Their recommendations will be key in determining the Federal role in this area, as well as serving as a guide in addressing the painful and tragic problem of child abuse and neglect. The projected authorization of $1 million for the board will ensure the continuation of its vitally important work.

NCCAN's failure to address its responsibilities has been buffered by the advisory board's success; therefore, the advisory board deserves the support of Congress for an expanded role.

Paramount to this discussion is the function of the State programs addressing child abuse and neglect prevention and treatment activities. A tremendous effort is made with meager resources.

We must wonder how a Nation that allocates, without a moment's hesitation, over $100 billion for the S&L scandal, finds $20 million adequate for grants to States to improve child protective services for our most precious resource—our children. I strongly support higher authorizations for these programs, as well as for adoption and family services programs.

We must also focus our attention on the vexing issue of child abuse fatalities. Why is it that we know more about the number and type of automobile accidents that occur in any given year than we know about the death of thousands of children attributable to child abuse and neglect?

I won't repeat that statement, but it was exactly the same wording I used more than 4 years ago, when we were considering the reauthorization of this bill at that time.

Many of us were moved by the "Frontline" documentary, "Who killed Adam Mann?" I hope most of you have seen that documentary.

The film concerned the death of 5-year-old Adam at the hands of his mother. We are enraged by the failure of the New York child protection "system" to save this child from the offending adult.

Questions of accountability were also at the forefront of a debate sparked by a series of articles in the Atlanta Journal/Constitution concerning the unexplained deaths of 51 Georgia children who were in the custody of the child welfare system.

Georgia State Representative Mary Margaret Oliver was appointed to co-chair a legislative study to determine how Georgia's laws and Federal regulations concerning confidentiality prevented accountability, thereby protecting the system while endangering children who are at risk of child abuse and neglect.

She is here today, and she will share the results of that study with us.

Dr. Michael Durfee and Dr. Susan Wells will testify on ways that States can use child fatality review panels to foster more accountability and reduce the number of child fatalities.

[The prepared statement of Hon. Major R. Owens follows:]

OPENING STATEMENT OF HON. MAJOR R. OWENS, CHAIRMAN
HOUSE SUBCOMMITTEE ON SELECT EDUCATION
HEARING ON
THE CHILD ABUSE PREVENTION, ADOPTION, AND FAMILY SERVICES ACT
FEBRUARY 27, 1992

TODAY'S HEARING ON THE CHILD ABUSE PREVENTION, ADOPTION, AND FAMILY SERVICES ACT WILL FOCUS ON:

1. THE ROLE OF THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (NCCAN)
2. THE ROLE OF THE U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT
3. EXPANSION OF CHILD ABUSE, ADOPTION, AND FAMILY SERVICES PROGRAMS
4. ISSUES OF CHILD ABUSE FATALITIES

THE GENERAL ACCOUNTING OFFICE (GAO), IN ITS TESTIMONY BEFORE THE SUBCOMMITTEE ON MAY 9, 1991, RAISED SERIOUS CONCERNS ABOUT THE ABILITY OF THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (NCCAN) TO PERFORM ITS LEADERSHIP ROLE IN IDENTIFYING, PREVENTING, AND TREATING CHILD ABUSE AND NEGLECT. THEY ALSO QUESTIONED THE ABILITY OF HEALTH AND HUMAN SERVICES TO MANAGE ITS GRANT WORKLOAD, WARNING THAT NCCAN MAY REPEAT PAST ADMINISTRATIVE FAILURES IF CONCRETE STEPS WERE NOT TAKEN TO CORRECT SHORTAGES IN STAFFING AND RESOURCES.

ALTHOUGH NCCAN WAS BEING REORGANIZED INTO THE NEW ADMINISTRATION FOR CHILDREN AND FAMILIES, AT THE TIME, GAO ADVISED THE SUBCOMMITTEE TO CONSIDER EITHER REDUCING ITS EXPECTATIONS FOR NCCAN OR PROVIDING OTHER AVENUES FOR

ACHIEVING THE GOALS OUTLINED IN THE LEGISLATION IF NCCAN ISSUES AND PROGRAMS WERE NOT GIVEN PRIORITY ATTENTION. TODAY, WE WANT TO DETERMINE THE EXTENT OF THE PROGRESS MADE BY NCCAN OVER THE LAST NINE MONTHS, AND BASED ON THIS ASSESSMENT, MAKE A RECOMMENDATION ON THE LENGTH OF THE REAUTHORIZATION FOR THIS COMPONENT.

THE CHALLENGES FACED BY THE NATION RESULTING FROM THE DRAMATIC INCREASE IN REPORTED CHILD ABUSE AND NEGLECT, AS WELL AS FAMILY VIOLENCE, DEMAND THAT STRONG LEADERSHIP ALSO BE PROVIDED BY NCCAN'S ADVISORY BOARD. SECRETARY LOUIS W. SULLIVAN, AT THE DECEMBER 6, 1991 NATIONAL MEETING ON CHILD ABUSE AND NEGLECT, TOLD THE AUDIENCE THAT THE "ADVISORY BOARD HAS BEEN A CATALYST FOR CHANGE ON BEHALF OF ABUSED AND NEGLECTED CHILDREN." THE ADVISORY BOARD, MADE UP OF VOLUNTEERS, HAS EXCEEDED OUR EXPECTATIONS OF LEADERSHIP. THE TWO REPORTS THEY HAVE COMPLETED ARE IMPRESSIVE TESTAMENTS TO THE WORK OF AN EXCEPTIONALLY DEDICATED GROUP OF PUBLIC SERVANTS. THEIR RECOMMENDATIONS WILL BE KEY TO DETERMINING THE FEDERAL ROLE IN THIS AREA AS WELL AS SERVING AS A GUIDE IN ADDRESSING THE PAINFUL AND TRAGIC PROBLEM OF CHILD ABUSE AND NEGLECT. THE PROJECTED AUTHORIZATION OF $1 MILLION FOR THE BOARD WILL ENSURE THE CONTINUATION OF ITS VITALLY IMPORTANT WORK. NCCAN'S FAILURE TO ADDRESS ITS RESPONSIBILITIES HAS BEEN BUFFERED BY THE ADVISORY BOARD'S SUCCESS; THEREFORE, THE ADVISORY BOARD SHOULD GET OUR SUPPORT FOR AN

EXPANDED ROLE.

PARAMOUNT TO THIS DISCUSSION IS THE FUNCTION OF THE STATE PROGRAMS ADDRESSING CHILD ABUSE AND NEGLECT PREVENTION AND TREATMENT ACTIVITIES. A TREMENDOUS EFFORT IS MADE WITH MEAGER RESOURCES. WE MUST WONDER HOW A NATION THAT ALLOCATES, WITHOUT A MOMENT'S HESITATION, ALMOST $100 BILLION FOR THE S&L SCANDAL, FINDS $20 MILLION ADEQUATE FOR GRANTS TO STATES TO IMPROVE CHILD PROTECTIVE SERVICES FOR OUR MOST PRECIOUS RESOURCE--OUR CHILDREN. I STRONGLY SUPPORT HIGH AUTHORIZATIONS FOR THESE PROGRAMS, AS WELL AS FOR ADOPTION AND FAMILY SERVICES.

WE MUST ALSO FOCUS OUR ATTENTION ON THE VEXING ISSUE OF CHILD ABUSE FATALITIES. WHY IS IT THAT WE KNOW MORE ABOUT THE NUMBER AND TYPE OF AUTOMOBILE ACCIDENTS THAT OCCUR IN ANY GIVEN YEAR THAN WE KNOW ABOUT THE DEATH OF THOUSANDS OF CHILDREN ATTRIBUTABLE TO CHILD ABUSE AND NEGLECT? MANY OF US WERE MOVED BY THE FRONTLINE DOCUMENTARY, "WHO KILLED ADAM MANN?". THE FILM CONCERNED THE DEATH OF FIVE-YEAR-OLD ADAM AT THE HANDS OF HIS MOTHER. WE ARE ENRAGED BY THE FAILURE OF THE NEW YORK CHILD PROTECTION "SYSTEM" TO SAVE THIS CHILD FROM THE OFFENDING ADULT.

QUESTIONS OF ACCOUNTABILITY WERE ALSO AT THE FOREFRONT OF A DEBATE SPARKED BY A SERIES OF ARTICLES IN THE ATLANTA JOURNAL/CONSTITUTION CONCERNING THE UNEXPLAINED DEATHS OF 51 GEORGIA CHILDREN WHO WERE IN THE CUSTODY OF THE CHILD WELFARE

SYSTEM. GEORGIA STATE REPRESENTATIVE MARY MARGARET OLIVER WAS APPOINTED TO CO-CHAIR A LEGISLATIVE STUDY TO DETERMINE HOW GEORGIA'S LAWS AND FEDERAL REGULATIONS CONCERNING CONFIDENTIALITY PREVENTED ACCOUNTABILITY, THEREBY PROTECTING THE SYSTEM WHILE ENDANGERING CHILDREN WHO ARE AT RISK OF CHILD ABUSE AND NEGLECT. SHE WILL SHARE THE RESULTS OF THAT STUDY WITH US. DR. MICHAEL DURFEE AND DR. SUSAN WELLS WILL TESTIFY ON WAYS THAT STATES CAN USE CHILD FATALITY REVIEW PANELS TO FOSTER MORE ACCOUNTABILITY AND REDUCE THE NUMBER OF CHILD FATALITIES.

We will begin our hearing, however, with the expert witness from the department, Dr. Wade Horn, the Commissioner, Administration for Children, Youth, and Families, of the Department of Health and Human Services.

We are pleased to have you with us today, Dr. Horn. You may proceed, Commissioner.

STATEMENT OF WADE HORN, PH.D., COMMISSIONER, ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC; ACCOMPANIED BY JOE MOTTOLA, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. HORN. Thank you, Mr. Chairman.

First, I would like to say that I had intended to have David Lloyd, the Director of the National Center on Child Abuse and Neglect accompany me here today, but he is unfortunately ill and at home and can't be here.

So, instead, my Deputy Commissioner, Mr. Joe Mottola is here. So, if you have any really tough questions, ask him, not me.

I do have a lengthy testimony that I have submitted for the record. I do have a shorter version that I would like to read.

Chairman OWENS. Your statement and the written statements of all of the witnesses will be included in the record in their entirety.

Mr. HORN. Mr. Chairman, at a time when most American children are thriving, the reality of child maltreatment presents a sad contradiction in American life. This contradiction, this stark juxtaposition between the typical American childhood and those childhoods seared by abuse or neglect was made even clearer to me during my recent work as a member of the National Commission on Children.

One of the major findings of the National Commission on Children was that it's a good time to be a child—usually. The opening paragraph of the Commission's report States that, "Most American children are healthy, happy, and secure. They belong to warm, loving families. For them, life is filled with the joys of childhood, and tomorrow is full of hope and promise."

And later, the report says, "The majority of young people emerge from adolescence healthy, hopeful, and able to meet the challenges of adult life."

But at the same time, there is a frighteningly familiar statistic. Over a million children each and every year are maltreated. Too many American families are simply failing at raising children. Some of the factors fueling this situation are largely beyond the control of individual families.

In many of our communities, traditional societal supports have deteriorated, resulting in a growing social isolation. Also, the daily lives of families and children, even those who are shielded from the personal effects of poverty, illness, and extreme misfortune, are being increasingly saturated with violence.

For example, a recent study of 168 teenagers who visited a Baltimore city clinic for routine medical care found that 24 percent had witnessed a murder and that 72 percent knew someone who had been shot.

Other causes of family dysfunction are the result of individual behaviors. Substance abuse, teenage pregnancy, dropping out of school, out-of-wedlock childbearing, and divorce all result from individuals' behaviors.

The result of this social morass that ensnares too many—not all, not most, but certainly too many—American families is children who are injured physically or emotionally.

Changing this grim picture will require American citizens to build coalitions of concern, cooperative alliances that include government as a partner but which also involve community associations, the corporate sector, educational establishments, religious organizations, parent groups—everyone who has a stake in the future of our children. Clearly, that is every American.

In the Department of Health and Human Services, we view our efforts to eradicate child abuse and neglect in a larger context of helping to develop healthy families, for such families form the foundation of a healthy society.

Indeed, I'm sure that we can all agree that strong and confident families are the building blocks of caring communities where, in an atmosphere of mutual responsibility and concern, children are free to grow up protected, nurtured, guided, and loved.

Since many of our programs in the Administration for Children and Families have as their goal strengthening families, we properly view even those programs outside of the purview of the National Center on Child Abuse and Neglect as integral to eradicating the root causes of child abuse by promoting the growth of strong families; programs like Head Start, Family Preservation Services, the JOBS Program, and enhanced child support enforcement.

When I testified before this committee last May, I mentioned that Secretary Sullivan had mounted an initiative to combat child abuse and neglect. This initiative is now underway and has several components, including increasing public awareness of the problem, encouraging all sectors of society to cooperate in combating the problem, and promoting intra- and inter-agency coordination of child abuse and neglect activities.

We are also taking steps to improve the effectiveness of the National Center on Child Abuse and Neglect. First, the organizational separation of NCCAN from the Children's Bureau has made it easier to identify and resolve issues quickly.

Second, we have increased the number of staff positions in NCCAN from 13 in 1989, to 26 in 1992.

Third, we have increased NCCAN's travel budget from approximately $6 million in 1990, to over $23 million in 1992. I'm sorry, I mean thousands. I'm so used to dealing in millions in this town, I get confused.

Mr. **Payne**. Maybe that's what it should be.

Chairman **Owens**. Good point.

[Laughter.]

Chairman **Owens**. You've made the best point of the day.

Mr. **Horn**. Hopefully, not in the travel budget.

So, let me clarify that for the record. The increase has been from $6,000 in 1990, to over $23,000 in 1992.

NCCAN is also pursuing a number of major new initiatives which are making a difference in the state-of-the-art in child abuse and neglect. For example, during 1991, NCCAN successfully implemented the Emergency Child Abuse and Neglect Prevention Services Program.

It also awarded a grant to the National Academy of Sciences to review and evaluate research done to date on child abuse and neglect and to develop a long term research agenda for the field.

It also began supporting the expansion of a cadre of new researchers through the funding of graduate research fellowships in the field of child abuse and neglect.

During the past 2 years, NCCAN has also worked to improve the collection of national data on the problem of child abuse and neglect, both by establishing the National Child Abuse and Neglect Data System or NCANDS, which coordinates data from annual State child abuse and neglect reports, and by awarding a contract for the third national study of the incidence of child abuse and neglect.

NCCAN has also undertaken initiatives to enhance its ongoing efforts. For example, NCCAN has increased its staff support for both the Inter-Agency Task Force and the U.S. Advisory Board.

The Inter-Agency Task Force, by the way, has recently published a guide to funding resources for child abuse and neglect and family violence programs, and has also created a consortium of Federal clearinghouses that are coordinating their child abuse and neglect information dissemination activities.

Over the past several years, NCCAN has convened a series of symposia and national meetings involving expert researchers and practitioners to explore critical national issues in child maltreatment.

I hope it's obvious from this testimony, and particularly from the longer version I've submitted for the record, that NCCAN has embarked on an ambitious agenda to strengthen its position as the focal point for Federal activities pertaining to combating chid abuse and neglect.

We are quite justifiably proud of our efforts to address this very difficult issue. However, no matter how many Federal initiatives NCCAN undertakes and no matter how many dollars the Federal Government spends, we must always recognize that, in the words of Secretary Sullivan, it will only be through the implementation of a new "culture of character" and the development of new "communities of concern" that we can ever fully address the problem of child abuse and neglect in our Nation.

Thank you for allowing me to appear. I'll be glad to address any questions you might have.

[The prepared statement of Dr. Wade Horn follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
370 L'Enfant Promenade, S.W.
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STATEMENT BY

WADE F. HORN, PH.D.

COMMISSIONER

ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES

ADMINISTRATION FOR CHILDREN AND FAMILIES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDUCATION AND LABOR COMMITTEE

SELECT EDUCATION SUBCOMMITTEE

U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 27, 1992

Thank you, Mr. Chairman, and members of the Subcommittee, for inviting me to testify on the reauthorization of the Child Abuse Prevention and Treatment Act. My name is Wade F. Horn, Ph.D., and I am the Commissioner of the Administration on Children, Youth and Families (ACYF). Mr. David W. Lloyd, the Director of the National Center on Child Abuse and Neglect (NCCAN), joins me here today.

At a time when most American children are thriving, the reality of child maltreatment presents a sad contradiction in American life. This contradiction, this stark juxtaposition between the typical American childhood and those childhoods seared by abuse or neglect, was made even clearer to me during my work as a member of the National Commission on Children.

One of the major findings in the final report of the National Commission on Children, was that it's a good time to be a child -- usually. The opening paragraph of the Commission's report states that "Most American children are healthy, happy, and secure. They belong to warm, loving families. For them, life is filled with the joys of childhood -- growing, exploring, learning, and dreaming -- and tomorrow is full of hope and promise." And later, the report says "The majority of young people emerge from adolescence healthy, hopeful, and able to meet the challenges of adult life.... They are progressing in school, they are not sexually active, they do not commit delinquent acts, and they do not use drugs or alcohol." There are, indeed, many trends about which we in the Administration for Children and Families may be hopeful.

But at the same time, there are frighteningly familiar statistics. 1.5 million children are maltreated or are in danger of maltreatment every year. About 60% of these children are educationally, physically, or emotionally neglected. Approximately 40% are physically, emotionally or sexually abused.

Too many American families are simply failing at raising children. Some of the factors fueling this situation are largely beyond the control of individual families. In many of our communities, traditional societal supports have deteriorated, resulting in growing social isolation. Also, the daily lives of families and children, even those who are shielded from the personal effects of poverty, illness, and extreme misfortune, are being increasingly saturated with violence. A study of 168 teenagers who visited a Baltimore city clinic for routine medical care, for example, found that 24 percent had witnessed a murder and that 72 percent knew someone who had been shot.

Other causes of family dysfunction are the result of individual behaviors. Substance abuse is an individual's personal choice. Teenaged pregnancy, dropping out-of-school, out-of-wedlock childbearing, and divorce all result from individuals' behaviors.

The result of this social morass that ensnares too many -- not all, not most, but certainly too many -- American families is children who are injured physically or emotionally. Changing this grim picture will require American citizens to build coalitions of concern, cooperative alliances that include government as a partner, but which also involve community associations, the corporate sector, voluntary organizations, the educational establishment, religious organizations, parent groups--everyone who has a stake in the future of our children. Clearly, that is every American.

I believe that through a number of significant activities, we are moving toward the goal of developing a society in which child maltreatment will no longer be tolerated. We view our efforts in the larger context of helping to develop healthy families, for such families form the foundation of a healthy society. Strong, healthy, and self-confident families are the building blocks of caring communities, where, in an atmosphere of mutual responsibility and concern, children are free to grow up protected, nurtured, guided, and loved.

Our emphasis is on prevention and the recognition that the causes of child abuse and neglect are interrelated. This approach is evident in key programs throughout the Administration on Children and Families, programs that, when viewed broadly, can be seen as integral to eradicating the root causes of child abuse by promoting the growth of strong families. For example:

- Head Start continues to evolve away from a simple child development program into a program of comprehensive design, aimed at building solid families and communities. It not only meets the developmental, health and nutrition needs of low-income children, it also works with parents to improve parenting skills, discourage drug and alcohol abuse, and to train parents for and help them to find jobs. Further, involvement in Head Start often draws parents out of patterns of isolation and alienation that can lead to child maltreatment, into the active, connected, community-oriented life of the Head Start center. As teachers' aides, volunteers, and members of the governing boards, many acquire their first and most important lessons in belonging to a community, along with the rights and responsibilities that go with it. Indeed, Secretary Sullivan often cites Head Start as the best model of his call for a new culture of character and communities of concern.

- Within the child welfare system, we continue to seek ways to avoid placing children into costly and possibly harmful foster care settings by working to strengthen families. We are establishing programs that promote intensive local community involvement in the daily lives, attitudes, and values of distressed families in an effort to prevent the dysfunctional behaviors that may lead to foster care placement.

- Recent reforms in Aid to Families with Dependent Children and child support enforcement were aimed directly at the values and cultural expectations that undergird these programs, suggesting a shift away from entitlement and toward the assumption of personal responsibility. We know that children are unlikely to flourish in families that are caught in a cycle of long-term dependency. The JOBS program (a work and training program for AFDC recipients to help them become self-sufficient) and child support enforcement thus play a critical role in improving the lives of children and preventing abuse by building parents' sense of self-worth. Becoming self-supporting strengthens a family in ways that long-term government assistance never will.

SECRETARY'S INITIATIVE ON CHILD ABUSE AND NEGLECT

Against this backdrop of increasing awareness of the complex and connected phenomena that result in child maltreatment, Secretary Sullivan has mounted an Initiative that involves all segments of society in the fight against child abuse. When I testified before this Committee last May, I mentioned that this Initiative had just been launched. The Initiative is now well underway and has several components: 1) increasing public awareness of the problem of child maltreatment; 2) encouraging all sectors of society to cooperate in combatting the problem; and 3) promoting intra- and interagency coordination of child abuse and neglect activities.

In support of the goal of enhancing public awareness, Secretary Sullivan has made child abuse the focal point of many speeches in the last two years. In Colorado, in Ohio, in Washington, D.C., the Secretary talked plainly to the American people of the Department's commitment to eliminating child abuse, and the role each American must play. In April, 1992, which is Child Abuse Prevention Month, the National Center on Child Abuse and Neglect will join the Secretary's office in mounting a major media and community awareness campaign, including the dissemination of "how-to" information on good program practices. As a byproduct of heightened consciousness, we expect to see an increase in the development of solutions appropriate for each State and community.

Second, in order to encourage organizations from all sectors of society to use their influence on behalf of children at risk of abuse, the Department is sponsoring a series of action meetings. The purpose of these meetings is to challenge leaders from business, social services, professional associations, criminal justice, education, the public sector, and religion to join us in a coordinated effort to prevent child maltreatment. The kickoff meeting of leaders from the various sectors with the Secretary was held in Washington, D.C. on December 6, 1991. The next phase is to have the participants at this meeting enlist the help of their State and local counterparts to plan and implement community-based activities to address the problem of child abuse and neglect. To do this, a series of meetings will be held in each of HHS' ten Regional Office cities during April, 1992. Over a period of several years, we expect to see an increase in individual and collective responsibility-taking for the fight against child abuse and neglect.

The third key ingredient of the Initiative is to increase government-wide coordination and cooperation. Within the

Department of Health and Human Services, a steering group with representatives from the Public Health Service, the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation, and the Administration for Children and Families are cooperating to make the best use of each component's resources and expertise to fight child abuse. These operating divisions are engaging in joint research and program planning, financing approaches, materials development, data collection and other activities that will add to our knowledge base about child abuse and neglect.

To encourage increased coordination among other Cabinet-level agencies with child abuse responsibilities, Secretary Sullivan developed a Memorandum of Understanding that was signed by the heads of the Departments of Health and Human Services, Education, Labor, Justice, Interior, Agriculture, Defense and Housing and Urban Development in December 1991. The Interagency Task Force on Child Abuse and Neglect, a group of some 30 representatives of 10 Cabinet agencies whose existence was established in P.L. 100-294, is closely involved in carrying out the intent of this Memorandum of Understanding. We expect that this agreement, and the work being done within the Department of HHS, will lead to cooperative research agendas, improved information utilization and dissemination, more efficient use of resources, and better service delivery on behalf of abused and neglected children and their families.

IMPROVING THE EFFECTIVENESS OF NCCAN

The strength of the National Center on Child Abuse and Neglect grew during Fiscal Year 1991. Having separated organizationally from the Children's Bureau, NCCAN's autonomy and access to quick decision-making have increased. By eliminating an organizational layer, we are now making optimal use of limited human and fiscal resources.

First, the organizational separation of NCCAN from the Children's Bureau has proven to be a positive move. This reorganization increased NCCAN's access to the Commissioner's office, making it easier to identify and resolve issues quickly.

The Department's increased attention to child abuse and neglect via the Secretary's Initiative, has led, as a secondary effect, to an increase in NCCAN's efficiency. With the assistance of additional management emphasis and the devotion of new time and staff energy from across the Department to the problem of child abuse, our capacity to achieve our goals is reinforced. For example, we at ACYF are working with the Department's Centers for Disease Control to enhance our data collection efforts. In addition, the Secretary's meetings held in Washington and the Regional Office cities are lending increased visibility and credibility to NCCAN.

NCCAN is pursuing a number of major new initiatives which are making a difference in the state of the art in child abuse and neglect. For example:

- During FY 1991, NCCAN successfully implemented the Emergency Child Abuse and Neglect Prevention Services program, a new $19.5 million discretionary grant program addressing the problem of parental substance abuse and child maltreatment. All of the 94 grantees under this program met in Washington two weeks ago.

- In FY 1991, NCCAN awarded a grant to the National Academy of Sciences to review and evaluate research done to date on child abuse and neglect and to develop a long-term research agenda for the field. The final report will be produced in FY 1993.

- During FY 1991 NCCAN began supporting the expansion of a cadre of new researchers through the funding of graduate research fellowships in the field of child abuse and neglect. The research community has also highlighted the need to draw minority researchers into the child abuse and neglect field and the granting of stipends at the doctoral level is one of several vehicles NCCAN will utilize.

- During FY 1990, NCCAN launched a Consortium for Longitudinal Studies of Child Maltreatment to address aspects of the life course of families at risk of child maltreatment, the consequences of child maltreatment and the impact of interventions. These studies give promise of contributing to our knowledge of the etiology and ecology of child maltreatment and providing valuable new insights into prevention, treatment and the organization of public and private protective services. NCCAN hopes to provide stable long-term funding for this initiative.

- NCCAN has played a major technical assistance and consultation role with the Public Health Service's Office of Disease Prevention and Health Promotion in crafting the child abuse and neglect objectives for Healthy People 2000, the National Health Objectives for the Department of Health and Human Services. Two of the objectives specifically relate to child abuse and neglect.

- During the last two years NCCAN has established a national data collection and analysis program, the National Child Abuse and Neglect Data System (NCANDS), which coordinates data from annual State child abuse and neglect reports. Technical assistance has been provided to States to help them collect and categorize their data in a manner that is most efficient for their needs and for participating in NCANDS. The first State data will be published in April, 1992.

  The development of NCANDS is being coordinated with the Department's development of the Adoption and Foster Care Analysis and Reporting System (AFCARS), with the long-term goal of integrating the two systems.

- Public Law 100-294 requires that NCCAN conduct research on "the national incidence of child abuse and neglect..." To fulfill this mandate, NCCAN has funded a series of National Incidence Studies to examine the national incidence of child abuse and neglect. A contract for the third such incidence study, known as NIS-3, was awarded on September 30, 1991 to WESTAT, Inc., and will include both the data collection and analysis required by the Congress and an examination of the extent to which incidents of child abuse and neglect are increasing or decreasing in number and severity since data were collected in 1979-80 (NIS-1) and in 1986 (NIS-2). The overall methodology used for the NIS-3 will be compatible with that used in NIS-1 and NIS-2 in order to enable longitudinal comparisons across the three data sets.

IMPROVING NCCAN'S ONGOING ACTIVITIES

NCCAN has also undertaken initiatives to enhance its ongoing efforts. For example:

- During FY 1990-1991, NCCAN increased its staff support of the Inter-Agency Task Force on Child Abuse and Neglect. The Task Force published the Guide to Funding Resources for Child Abuse & Neglect and Family Violence Programs and has created a consortium of Federal clearinghouses that are coordinating their child abuse and neglect information dissemination activities. NCCAN is also providing leadership in coordinating initiatives of Federal agencies in conducting background checks for those providing child care and giving staff support for the Research Advisory Committee.

- During FY's 1989-1991, NCCAN convened a series of symposia involving expert researchers and practitioners to explore critical national issues in child maltreatment, including: Child Neglect, Treatment Approaches to Child Maltreatment, Systems Issues at the Community Level, Child Sexual Abuse, Judicial Needs Relating to Child Sexual Abuse, and Child Abuse and Neglect Prevention.

These symposia have resulted in the development, publication and dissemination of nationally significant documents which represent current state-of-the-art knowledge and effective practice protocols of benefit and interest to professionals across many disciplines. They have also provided for recommendations for the NCCAN research and demonstration priority areas.

During FY 1991, NCCAN also co-sponsored a national meeting on parental substance abuse and child maltreatment.

During FY 1992, a symposium on Risk Assessment in Child Protective Services has been held, and additional symposia on Bridging the Gap Between Research and Practice, Hospital-Related Issues in Child Maltreatment and Chronic Neglect, and Law Enforcement Needs in Child Sexual Abuse Cases are planned.

o During the last several years, NCCAN has successfully implemented a series of Inter-Agency Agreements for collaborative activities with the Department of the Navy, the Bureau of Indian Affairs in the Department of the Interior, and the Bureau of Maternal Child Health Resources Development in HHS. These efforts have resulted in the significant research findings on risk factors among Navy fathers; improved service for Native Americans; and development of a child protective services and public health services infrastructure in the Pacific Basin.

NCCAN also participates in an inter-agency agreement with the National Institute for Child Health and Development to support research on the longitudinal effects of parental substance abuse on the life course of children.

During FY 1992, NCCAN will continue to support inter-agency agreements with other Federal agencies for research, demonstration projects, and data collection.

- A Program Instruction setting forth uniform reporting requirements for all four NCCAN State Grant Programs was developed in conjunction with Regional Offices and the Child Abuse and Neglect State Liaison Officers to ensure consistent reporting requirements among the Regional Offices with respect to the Basic State Grant and funds for the Medical Neglect/Disabled Infants.

- NCCAN has also begun an initiative to improve the administration of the four State Grant Programs with respect to such other critical issues as the provisions regarding confidentiality of child protective services case records. Recommendations will be fully discussed at a cluster meeting of State representatives for all four programs, after which NCCAN will begin the implementation process.

- During FY 1991, NCCAN began implementing a plan for reducing duplication and improving coordination with regard to the activities of the

Clearinghouse on Child Abuse and Neglect Information, the National Resource Center on Child Abuse and Neglect, the National Resource Center on Child Sexual Abuse, and the Clearinghouse on Medical Neglect of Infants With Life-Threatening Disabilities.

- During FY 1991, NCCAN began the process of updating the "User Manual" series, which present information about best practices in addressing child abuse and neglect. During FY 1991 NCCAN also began the process of revising "Child Protection: Guidelines for Policy and Program," for dissemination to child protective services agencies.

Clearly, NCCAN has embarked on an ambitious agenda to strengthen its position as the focal point for federal activities pertaining to combating child abuse and neglect. We are proud of our efforts to address this difficult issue. However, no matter how many federal initiatives NCCAN undertakes, we must always recognize that, in the words of Secretary Sullivan, it will only be through the implementation of a new "culture of character" and the development of new "communities of concern" that we can ever hope to effectively address the problem of child abuse and neglect in our nation.

In conclusion, I want to thank the Subcommittee for this opportunity to present our views. We look forward to continued cooperation with Subcommittee staff and concerned citizens from all over the nation as we strive to provide Federal leadership on behalf of children and families.

I would be pleased to answer any questions you may have.

Chairman OWENS. Thank you, Mr. Commissioner.

Could you begin by telling us why you still have not delivered six reports which were required by legislation by April, 1991, and you did promise for September, 1991?

Mr. HORN. We had hoped to be able to get them in by the fall of last year. I can tell you the status of those reports.

Chairman OWENS. Fall of this year or last year?

Mr. HORN. Last year.

The status of those reports is that three of them are now in clearance stages within the Department. Three others are now in draft form and are being edited for final clearance, and one of them is still being negotiated in terms of data collection with the Office of Management and Budget.

We had hoped to be able to get all of those reports cleared up before this hearing, and unfortunately we haven't been able to do that. We are working as diligently as we can on getting them done.

Chairman OWENS. You can't give us any projections on dates at this point?

Mr. HORN. I have learned to be a little bit more cautious in my projection on dates. I can tell you that the three reports that are in Departmental clearance should be up here fairly soon.

The other three reports that are now in draft form or being edited, should be getting into Departmental clearance very soon, and the one remaining troublesome issue is with the one report that is awaiting final negotiations with OMB regarding data collection.

Chairman OWENS. I know that in your written testimony you sounded on the U.S. Child Abuse Advisory Board. Yet, they have produced two outstanding reports and they have received high accommodations from the Secretary.

What have you budgeted for the advisory board for this fiscal year 1992 and 1993?

Mr. HORN. Excluding the salaries and expenses money that goes to paying the per diem that each board member receives for serving on the board as well as travel expenses for going to meetings, we have budgeted approximately $200,000 for contract support to allow them to continue their work.

So, the total amount budgeted to support the U.S. Advisory Board is in excess of $200,000, because we also draw down from our salaries and expenses budget, in order to pay the per diem that each of the advisory board members receives, which is, I think, approximately $1,000 per meeting, and also for their travel for going to and from meetings.

Chairman OWENS. We've heard that States may interpret the Federal regulations to not allow multi-agency review teams to function because they have interpreted State law to mean that if the team is acting in a non-investigatory way, records of one agency cannot be shared with another.

Do you acknowledge that there may be problems in this area; do you have any proposals to deal with those problems?

Mr. HORN. I know there's been some problems at the State level regarding the sharing of information. This has to do with the whole issue of confidentiality of records.

As you know, Mr. Chairman, in the regulations, there are 11 exceptions to the confidentiality provisions regarding reports of abuse and neglect. Those exceptions include, for example, allowing information to be shared across agencies that have a legitimate interest in the investigation and the treatment of a particular child abuse case.

It also allows for an exception in terms of legitimate oversight agencies within the government. For example, an exception is allowed for transfer of records to child fatality review teams.

I think there is some confusion, perhaps, at the State level, as to the extent to which they are allowed to transfer records, but there are, in fact, exceptions to this strict confidentiality provision.

Having said that, we are taking a close look at these provisions. In fact, in January of this year, we convened a working group consisting of both Federal Agency staff and representatives from the States to discuss the issue of confidentiality.

We intend, in a future meeting, sometime this spring, to discuss the recommendations of that working group with representatives from all of the States, and clarify for those State representatives what it is that they are allowed to exempt from the confidentiality statutes.

I do think that the Federal statute and Federal regulations allow enough flexibility at the State level to ensure that records can, in fact, be transferred from one agency to another, provided those agencies have a legitimate interest in that child—that particular case—as well as ensuring that the State has adequate protections for the continued confidentiality of those records.

There are some difficulties, perhaps. For example, we may need to take a look at whether or not we need to adjust the Federal regulations regarding the sharing of information with prospective adoptive parents regarding children who have been placed into foster care because of child abuse or neglect.

But in the main, we're pretty satisfied with the confidentiality provisions, but not satisfied with the degree to which the States understand the flexibility that they do have under Federal statute and regulations.

Chairman Owens. Would you comment on the Georgia situation with respect to this issue. Georgia, as I understand it, has liberalized their laws to allow for a limited amount of information to be released related to deceased children.

As I understand it, all Georgia statute requires is that if a person calls the Department of Human Resources, the Department can answer two questions from the caller. First, was the child subject to a child abuse investigative report, and second, whether the report was confirmed or not confirmed.

Mr. Horn. Well, as I understand the Georgia statute, what it would do is it would allow any individual in any capacity, who simply has the name of a child, to call the agency and have information released from the confidential record.

I'm not so sure that that serves the interests of the child. I'm not sure that serves——

Chairman Owens. If the child is deceased; it says for deceased children.

Mr. **Horn**. I'm not sure it serves the interests of the entire system.

One of the things that we have to be clear about is that part of the reason why the confidentiality statute is there—the reason why in the wisdom of those who, in fact, enacted the confidentiality statute at the Federal level in the first place is that the statute exists not only to protect the interests of the child but also the interests of the family of the child, and the interests of the reporter.

There is a great deal of concern that there would be a chilling effect on the willingness of people to report an instance or a suspicion of child abuse or neglect if, in fact, it might be that later on their name could show up on the front pages of a newspaper.

So we are concerned that we don't do anything to put that kind of a chilling effect on the system; a system defined not only as those who work in child protective services, but to include the entire community, the community whom we rely upon, to report suspicions of child abuse and neglect.

Chairman **Owens**. Thank you. We will be hearing more about this particular Georgia situation later in this hearing. There are a number of other questions that I have, Commissioner, which I will submit to you in writing in the interest of time.

I do want to know, in view of the fact that you are not able to meet certain deadlines and your unit has some Herculean tasks before it, why did the staff authorization drop since the GAO testified in May of last year?

Mr. **Horn**. I think the thing to look at is how many people we have working in NCCAN as well as total staff authorization.

We have gone from 13 positions in NCCAN in 1989, to 26 positions today. Now it is true that we are currently recruiting for three of those positions, so we are not yet at full strength. But once those three recruitment actions are completed, then we'll be up to 26 people working in the national center. That's a doubling of the staff since 1989.

In addition to that, we have more than quadrupled the amount of travel resources available to the staff in the national center—maybe not to $23 million, but certainly to $23,000, in terms of travel resources. So I think that we have made great strides over the last 3 years.

In addition, we have increased support to the Inter-Agency Task Force. We have also increased support to the U.S. Advisory Board on Child Abuse and Neglect. And we have, as I had said we would, gone out and done a national search to find someone with a national reputation in child abuse and neglect to head the national center. We did that. We did that quite successfully.

I'm disappointed that David Lloyd is, unfortunately, ill and couldn't be here today with us. But I think that, by all accounts, David Lloyd has infused a new energy and vitality to the national center.

So I'm confident that, particularly once those three national recruitment actions are completed and we are up to full strength of 26 people in the national center—26 positions—that we can, in fact, get all of the work done that needs to get done.

So, I'm pretty pleased with where we are at in terms of staffing levels in the national center.

Chairman **Owens**. We appreciate your appearance today, Commissioner, and I certainly want to submit additional questions to you in writing.

I want to state publicly that we are not satisfied with the answers you have given with respect to the submission of reports. Those reports were considered important, and we would like you to have definite dates by which the reports that are due to Congress will be submitted, or some detailed reasons why they have not been submitted.

I yield to Mr. Ballenger for questions.

Mr. **Ballenger**. Thank you, Mr. Chairman.

Dr. Horn, in Congressman Goodling's testimony, for the lady that spoke in favor of protecting families, maybe, of not going too far in this area, she brought up a point that I never had thought of before.

But is there such a thing as professional training in this country today? Are we assisting at the government level in somehow trying to get universities or whoever it would be to set up programs to train people to understand this problem and to be able to recognize the problem when they see it?

Mr. **Horn**. There are two sources of Federal funds to enhance training in the area of child welfare services in general.

First of all, we do have a specific discretionary grant program called Child Welfare Training. In fact, we have asked for, in the President's 1993 budget, an increase of $2 million for that program so that we can enhance training at the undergraduate, graduate, and staff level.

In addition, through Title IV-E of the Social Security Act, there are moneys available to reimburse States for a portion of the costs of training their staff.

In fact, the training provision in Title IV-E is an open ended entitlement program, so there is money available to do that.

Have we done a good job nationally in getting the folks that work in child protection services, or in any child welfare agency, training? I think we can do better. Indeed, we have been trying to publicize the availability of these Title IV-E training funds more widely to the States and encourage them to take more advantage of it. So, clearly, there is a need for more training. We are trying to fulfill that through those two programs. Again, we added $2 million to the child welfare training program in order to show our commitment to increasing training. In addition, as I mentioned in my testimony, we've also started what we anticipate being an annual funding of graduate research fellowships for promising young researchers in the field of child abuse and neglect.

Mr. **Ballenger**. In my past life, I once upon a time was county commissioner in North Carolina. We were in charge of the social services department and the funding and so forth.

One of the greatest complaints we had—in fact, if you take a room the size of these tables here, and build shelves—say six inches apart, and run them all up the side of all of the walls, the social services department then filled that up with boxes of forms that were necessary to fill out.

I mean, if I were a social services worker and had to sit there and recognize that there are all kinds of problems that I should be serving today, but due to the fact that I have all of this government paperwork, I can't do it until day after tomorrow—are you making any effort to somehow assist the program by cutting out all the garbage that you demand?

I'm not saying you, personally, but what our Federal Government demands.

Mr. **Horn**. Right.

Mr. **Ballenger**. It's really a very destructive program, because it not only—every social worker I've ever seen had a desire to do good work. But then all of a sudden—not all of a sudden, but just on a regular basis—the Federal Government's demands for paperwork removes their opportunity to provide the service they want to.

Mr. **Horn**. I think you are absolutely correct.

And in fact we have a rather dramatic legislative proposal in the President's 1993 budget to try to do precisely what you are suggesting.

In Title IV-E of the Social Security Act there are, in my view, some fairly onerous kinds of paperwork requirements necessary to substantiate claims under the Title IV-E program, particularly in terms of administrative costs and in terms of training.

One of the things that we are suggesting that we do is that we do away with the IV-E administrative costs program and collapse that into a new capped entitlement program, where this money would be distributed to the States in a very flexible manner, so they wouldn't have to go through onerous paperwork requirements to claim the money.

In fact, under this legislative proposal, we've allowed the projected growth of that program to continue so that there is a real increase in money available to the States.

For example, in 1993, if that proposal is enacted, almost $1.3 billion will become available to the States to use in a very flexible manner to support child welfare services in general. That can be to enhance child protective services, to enhance treatment services, to enhance whatever it is they'd like to enhance about the provision of services to children.

That's $1.3 billion. That's a 20 percent increase over what is available in 1992. That amount of money would grow from $1.3 billion to almost $2.2 billion in just 5 years.

So what we are trying to do is take a program which we consider to be overly burdensome to the States that requires far too much paperwork to claim money, and to put it aside in favor of a new flexible pot of money that States can use for a variety of purposes, how they see fit.

You know, I think the whole issue of burdensome paperwork is a very important one and, quite honestly, I am disturbed by some of the reforms that are being suggested that go in the opposite direction—that in fact would, in my view, require extraordinary reporting on the part of the States in order to access moneys available in this area.

So I think we have to always keep in mind that whatever we do, let's not tie so many strings to it when we give it to the States, that it is so overburdening in terms of paperwork that we force people to spend all their time doing paperwork trying to get the money rather than providing services.

Mr. **Ballenger**. One more question, along that very same line, I was sitting here looking at the Senate present budget for the year, and then the Senate proposal. It looks like—and I'm not talking about the dollars and cents, but the numbers of different programs that are added—it looks like there are at least six or seven new programs that are added.

I'm quite sure the way we write bills up here, that's six or seven more sets of paperwork that you have to have to get it.

I'm just curious if there isn't some way—I mean, child neglect and child abuse is very important to everyone, I think. Yet, what I'm looking at here, there must be 14 different programs that are involved.

You say that you are trying to develop better communication between the various and sundry agencies, but if we keep creating new ones every year in Congress, it just seems to me we are compounding the difficulty that we have created to start with.

Am I somewhere near the truth?

Mr. **Horn**. I think you are absolutely near the truth. In fact, I think there is a growing consensus in this country that one of the things that prevents us from truly providing, at the local level, comprehensive and holistic support services for families is the fact that we have this incredible number of highly categorical, highly prescriptive programs. By the time these funds get down to the local level, they can't effectively mix funding streams in order to have a comprehensive array of services to support at risk children and at risk families.

So the Department has maintained steadfastly that we are opposed to reform efforts that increase the burden on States, that increase the number of categorical programs, that increase the prescriptiveness of those programs, and the burdensome requirements that reporting for each of these programs may bring about.

In fact, what we need to do if we are truly interested in reform, in my view, is to figure out ways to reduce the number of categorical programs and increase the flexibility so that those who are interested and want to provide services to families are given the ability to do that rather than sitting around and doing paperwork all day long.

Mr. **Ballenger**. One more thing. I spent 12 years on the Appropriations Committee of the North Carolina House and Senate. All we did, day in and day out in trying to figure out our budgets, were all the gimmicks that were created up there, or do you want to take the effort to do this, or is it too much trouble or can we find the funding here at the State level, and so forth.

I just hope that the programs could be consolidated, the effort that could be made to create less burdensome administration to the State and mostly at the local level, because that is where the rubber hits the road.

Mr. **Horn**. That's right.

Mr. **Ballenger**. It's not done here in Washington. It is not done in Raleigh, North Carolina. In my particular area, it is done in Hickory, North Carolina.

If we could just get the money to that level, to assist the people that are really having to do the job, I think we really would have accomplished something. I hope your effort, on that part, will turn out good.

Meanwhile, I'll turn it back over to you, Mr. Chairman.

Chairman **Owens**. Thank you.

Mr. Payne.

Mr. **Payne**. One of your points was that you were beginning a program to expand the quandary of new research people through graduate research fellowships to attempt to get more minority participants in the program.

Have you had any success in this 1991 program that you started?

Mr. **Horn**. I think we funded either four or five such fellowships. I can provide you the names and the addresses of each of the recipients of those fellowships. We hope to be able to provide a greater number of those this year.

We are always limited by the availability of funds, but you are quite correct in pointing out that one of the purposes of these graduate fellowships is to support minority researchers who have an interest in this field.

Mr. **Payne**. That's very good.

I agree that a lot of paperwork is really unnecessary. I also find it a little alarming when we find that you have available people from particular communities who are in many instances excluded from being a part of the solution, in contracts as providers of services.

In many instances, we find that we lack Hispanic and African-American people in the professional aspects of the services that are provided in contracts. The various reports that are being requested, in most instances, do not go where the rubber hits the road, as my colleague said.

So I wonder, is there any program that you have that might have people that are more associated and involved in understanding the particular problems in some urban areas or even in rural communities?

Mr. **Horn**. I think there are a number of things that we have funded over the last few years that would address the kinds of concerns you are talking about.

For example, in 1990, we funded through NCCAN a demonstration program called the People of Color Leadership Institute. A representative from that grantee is here today. The purpose of that grant is to encourage, support, and strengthen culturally, ethnically, and racially diverse national leadership in this field.

In addition, one of our proposed priority areas for funding this year has to do with demonstrations in the area of culturally sensitive prevention demonstration programs for servicing populations of different cultures at risk for child maltreatment.

So I think that we've tried to be sensitive to the issues of the minority community and tried to fund specific programs to deal with those issues. I think, also, we've done a fair amount to try to strengthen the kind of local community efforts to prevent child abuse and neglect.

For example, in 1989, we funded nine community-wide prevention demonstration grants to determine how local communities can work together in building coalitions to prevent the tragedy of child abuse and neglect.

Wherever we can, we take the approach that where the work really gets done is at the local level, and we need to support those efforts.

Mr. **Payne**. Thank you. I don't have any other questions. There is a report due in April, 1992, and finding that you are six reports behind, I'm almost fearful to ask whether you think that report will be out in April.

Mr. **Horn**. Part of the difficulty in the overdue reports has to do with the history of what we consider to be understaffing at the national center.

The fact that we've increased staffing levels from 13 in 1989 to 26 today suggests that we did perceive an understaffing problem at NCCAN.

Consequently, we've been playing catch-up with some of these reports, and it just takes a while to get some of that catch-up done. But, we are confident that we are now in a better position to be able to get reports to Congress on time.

There are some examples, however, of Congressionally-mandated reports that rely upon information that we get from the States. Due to our reliance on the States providing us with information, there is a lag time that makes some of those reports difficult to complete within the timelines.

But no one is happy, and Mr. Chairman, I did not mean to suggest that anybody is happy with the fact that there are overdue reports to Congress. We take such reports very seriously.

We have been working hard to try to get those reports up here. Like I said, part of the reason for that backlog is the historical understaffing in NCCAN. That's why we've doubled the size of the staff in NCCAN. We anticipate having a better track record on getting reports up here in the future.

Mr. **Payne**. Thank you very much.

I'm just curious to know if there were slots available, or did you have to increase the size of the agency? Do you have any history about why it was so understaffed—13 people to run a national organization like this?

Mr. **Horn**. Well, clearly, when I came on board in 1989, I didn't think that that was an adequate staffing level, so I have used whatever creative means I could to increase the number of people working in the national center.

The reason that there are three staff positions open is that we have had one recent retirement, and then authorization to recruit two additional positions as well.

So I don't think there is anything unusual about those three positions being open, but it will be useful to us when those three are also filled, and we're up to a full complement of staff.

Mr. **Payne**. Thank you, Mr. Chairman.

Chairman **Owens**. Mr. Commissioner, we would not want to be guilty of overburdening your agency with unnecessary paperwork.

We would welcome any case you want to make for reducing the number of reports. If you don't think those reports are necessary, make the case. We think they are important, and we think our requests have been reasonable, but make the case if that's so. We welcome that.

As I said before, we will be in touch with you with additional questions that we'd like to have answers to before we proceed on this reauthorization.

Thank you very much for appearing today

Mr. **Horn**. Thank you.

Chairman **Owens**. Panel Two consists of Mr. Joseph Delfico, Director of the Income Security Issues, General Accounting Office; Mr. Howard Davidson, Chairman, U.S. Advisory Board on Child Abuse and Neglect; and Mr Tom Birch, Legislative Counsel, National Child Abuse Coalition.

Please be seated. Mr. Delfico, you may proceed.

STATEMENTS OF JOSEPH DELFICO, DIRECTOR, INCOME SECURITY ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC; HOWARD DAVIDSON, U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT, WASHINGTON, DC; AND TOM BIRCH, LEGISLATIVE COUNSEL, NATIONAL CHILD ABUSE COALITION, WASHINGTON, DC

Mr. **Delfico**. Thank you, Mr. Chairman.

With me today is Mr. Robert MacLafferty, Ms. Elizabeth Oliveras, and Pamela Brown, who helped prepare this testimony. With your permission, I'd like to submit the full testimony for the record and present a brief summary.

Chairman **Owens**. It will entered in its entirety into the record.

Mr. **Delfico**. Thank you, Mr. Chairman.

In our previous testimony, we reported that an HHS reorganization established the Administration for Children and Families, but ACF's organizations and their potential impact on NCCAN are not yet known.

We expressed the concern that NCCAN issues might not be given priority attention within ACF. It appears that the reorganization has had a positive effect on NCCAN and has given NCCAN more visibility within ACF.

With regard to grant administration, NCCAN's grant workload, however, has increased substantially. NCCAN's 1990 reported grant workload rose from 288 grants to 392 in 1991. This is over a 35 percent increase in workload.

Since our May, 1991 testimony, NCCAN has made modest progress in administrating this grant workload. Earlier, we reported that NCCAN relied on periodic group meetings with its grantees for the purpose of monitoring grantees and made few visits for such purposes. Since then, NCCAN has made site visits to 15 of its 392 grantees.

In our prior testimony, we expressed a concern that shortages of resources for NCCAN's grant monitoring activities prevented NCCAN from complying with HHS policies.

We still have this concern. HHS's Grants Administration Manual requires that on-site visits should be made at least annually to each discretionary grantee, subject to the availability of resources. In 1991, NCCAN visited less than 15 percent of its grantees.

In our previous testimony, we reported that NCCAN was procuring a new contractor to operate the National Clearinghouse on Child Abuse and Neglect. NCCAN has procured a new contractor and has moved forward on new program initiatives regarding the management of clearinghouse operations in conjunction with the two resource centers.

We are concerned, however, that the clearinghouse does not satisfy the captive mandate to identify potentially successful programs. The final grant reports that may evaluate program outcomes are produced by grant recipients and have not been independently validated.

We continue to believe NCCAN should evaluate grant programs to identify those that are successful and disseminate this information through the clearinghouse.

NCCAN has met the timetable we identified in our May testimony for the implementation of the CAPTA-mandated National Chid Abuse and Neglect Data System. NCCAN has essentially completed the first phase of the two-phase data collection effort and NCCAN plans to distribute this information in March of 1992.

Since our last testimony, NCCAN has not submitted, as you noted earlier, six CAPTA-mandated reports. NCCAN indicated that these reports, which were originally due between 1986 and 1990, would be issued no later than September, 1991.

These reports have been drafted, but are still under ACYF, ACF, or HHS review. NCCAN did not provide us with a projected issue date for any of these reports.

In May, 1991, we reported that NCCAN staffing and budget shortages hindered NCCAN's ability to manage child abuse and neglect programs. We reported that NCCAN was authorized 21 positions, and had 14 full-time staff and had 7 unfilled positions.

Currently, NCCAN is authorized 20 positions, one less than in 1990, and has 16 full-time staff, one of whom is detailed elsewhere, and 4 unfilled positions, all for professionals.

In our earlier testimony, we reported that staff shortages contributed to heavy workloads for the staff. This is still the case. The NCCAN workload has increased substantially and its staff authorization has dropped.

NCCAN officials believe that NCCAN needs at least 10 more staff to effectively manage its grant workload with expertise in areas such as child protective services, regulatory and legislative research, planning, statistics, data analysis, and chronic neglect research.

We have been asked by your committee to comment on NCCAN's ability to handle additional grant responsibilities in S.838, which proposes new child abuse treatment improvement grant programs.

NCCAN's program responsibilities have increased, as I've mentioned earlier, over several years through successive CAPTA amendments. Yet, NCCAN's resources have not increased, nor has NCCAN been able to meet its CAPTA responsibilities with its current resources.

NCCAN also does not have the expertise or resources to assume responsibility for the S.838 proposed grant program. If NCCAN is made responsible for the expanded role proposed by S.838, without additional resources, NCCAN would have to reduce its already limited CAPTA grant administrative activities.

In our May 1991 testimony, we concluded that staff shortages kept NCCAN from fully carrying out its mission and CAPTA mandates. Congress should consider reducing its expectations for NCCAN, or seek other means for achieving CAPTA goals.

Since then, NCCAN has made some progress in monitoring grant programs, coordinating clearinghouse and resource center activities, and completing the first data collection phase of the data system.

However, all of their efforts represent a modest beginning in light of NCCAN's substantial and increasing workload. We still believe that NCCAN's limited resources continue to hinder its ability to become a leader in child abuse and neglect prevention and treatment.

Mr. Chairman, this concludes my brief statement. I'd be happy to answer any questions you may have.

[The prepared statement of Joseph Delfico follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Select Education, Committee on Education and Labor, House of Representatives

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CHILD ABUSE AND NEGLECT

Progress of the National Center Since May 1991

Statement of Joseph F. Delfico,
Director of Income Security Issues,
Human Resources Division

GAO/T-HRD-92-14

GAO Form 160 (12/91)
OPR: OIMC/PCC

SUMMARY

The Chairman, Subcommittee on Select Education, House Committee on Education and Labor, asked GAO to provide information on the National Center on Child Abuse and Neglect's (NCCAN) progress, since our May 9, 1991 testimony, in fulfilling its mission under the Child Abuse Prevention and Treatment Act (CAPTA). The Chairman specifically requested that GAO examine NCCAN's progress in obtaining resources, such as staffing and budget, to fulfill its mission of identifying, preventing, and treating child abuse and neglect, and to comment on whether NCCAN can assume a role in S. 838 (Child Abuse, Domestic Violence, Adoption and Family Services Act of 1991).

To assess NCCAN's progress, GAO reviewed (1) the reorganization of components within the Administration for Children, Youth and Families (ACYF) and its effect on NCCAN; (2) NCCAN's current efforts to monitor its grantees, manage the clearinghouse and resource centers, implement the National Child Abuse and Neglect Data System, and complete CAPTA-mandated reports; and (3) changes in NCCAN's staffing levels, expertise, and travel budget.

In general, NCCAN's placement within the ACYF structure, as a result of the reorganization, appears to have improved its ability to exercise control over its budget and policy initiatives. The reorganization eliminated a level of approval for NCCAN and enabled NCCAN to directly present staff and budget requests and policy initiatives to ACYF.

Since GAO's May 1991 testimony, NCCAN has filled four open positions but its staff authorization has dropped by one. Moreover, NCCAN has only partially met its CAPTA responsibilities. While NCCAN has prepared CAPTA-mandated reports, all the reports still have not been issued. With a travel budget of slightly over $6000, NCCAN was able to visit 15 (3.8%) of its 392 grantees. Though NCCAN has a budget of $23,000 for monitoring in fiscal year 1992, we question whether this will permit NCCAN to perform enough site reviews to effectively monitor grantees. NCCAN has still not been able to assess the adequacy of technical assistance it provides to grantees.

Regarding a potential role in S. 838, we question whether NCCAN has the staff or expertise to administer S. 838's proposed Child Abuse Treatment Improvements Grant Program. NCCAN's Director has indicated that, with additional administrative support, NCCAN could share the added responsibility with the Children's Bureau, which administers services emphasized by S. 838. We believe that NCCAN is unable to meet its CAPTA responsibilities with its current resources. Assigning NCCAN responsibility for S. 838 without additional resources may further limit NCCAN's ability to administer its grant workload as well as its ability to effectively administer the new responsibilities.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to update our previous testimony on the National Center on Child Abuse and Neglect's (NCCAN) implementation of Public Law 100-294, the Child Abuse Prevention and Treatment Act of 1988 (CAPTA). Along with information on the Department of Health and Human Service's (HHS) recent reorganization and its effect on NCCAN, you asked for information on NCCAN's progress, since our May 1991 testimony, in obtaining more staff, expertise, and travel funds to accomplish its CAPTA responsibilities. These responsibilities include administering grants, ensuring that the clearinghouse and resource centers disseminate child abuse and neglect information and provide technical assistance, developing the national data collection system to record statistics on the incidence of child abuse nationally, and issuing CAPTA-mandated reports on selected child abuse and neglect issues. You also asked us to comment on a potential role for NCCAN in administering the proposed Child Abuse, Domestic Violence, Adoption and Family Services Act of 1991 (S. 838).

In summary, the reorganization has had a positive effect on NCCAN, by allowing it to bring child abuse and neglect issues to the direct attention of ACYF and compete for resources on an equal basis with other ACYF components. NCCAN has made progress toward meeting its CAPTA responsibilities but has not fully met all of the law's requirements. Although NCCAN made slightly more site visits to grantees in 1991 than in 1990, it has not evaluated its technical assistance or issued CAPTA-required reports to the Congress. NCCAN improved the clearinghouse's ability to disseminate information but has not yet identified potentially successful programs. NCCAN has made progress on and will soon complete the first phase of the national data system. Despite the progress, however, we believe that NCCAN's limited resources will continue to prevent it from effectively managing its grant workload, which now exceeds 390 grants annually. Thus, assigning NCCAN responsibility for the grant program proposed by S. 838 without additional resources would further limit its ability to manage the current workload or reduce its ability to effectively manage the new program.

REORGANIZATION OF CHILDREN AND FAMILY SERVICES

NCCAN is an agency within the ACYF, which is a part of the Administration for Children and Families (ACF). In our previous testimony, we reported that an HHS reorganization established the ACF but that ACF's organizational plans and their potential effect on NCCAN programs were not yet known. We expressed a concern that NCCAN issues might not be given priority attention. It now appears that the reorganization has given NCCAN more visibility within ACF. NCCAN was removed from the Children's Bureau and placed at the same level. NCCAN now reports directly to ACYF, thereby eliminating a level of clearance. NCCAN is now able to make direct requests for staff and budget and bring child abuse and neglect issues to the direct attention of ACYF. The true effect of this reorganization will become more apparent, however, after some time has passed and a better comparison can be made with the prior organizational structure.

GRANT ADMINISTRATION

NCCAN's grant workload increased substantially in the past year. NCCAN's reported workload increased from 288 grants, amounting to \$39.2 million, in 1990 to 392[1], amounting to \$68.5 million in 1991. NCCAN's active grants[2] included 108 basic state grants (including medical neglect/disabled infant grants), 47 challenge grants, and 101 discretionary grants. NCCAN also awarded 42 grants under the Children's Justice Act (P.L. 99-401). NCCAN was also responsible for awarding and managing 94 grants under the Emergency Child Abuse and Neglect Prevention Services Program.

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[1] In our 1991 testimony, we reported challenge and Children's Justice Act grants awarded in fiscal year 1990. To be consistent with our 1991 testimony, we excluded 47 challenge grants and 43 Children's Justice Act grants from NCCAN's total grant figures since these grants were awarded in fiscal year 1990 and had terms which overlapped into 1991.

[2] NCCAN awards public and private entities two types of grants: emergency services grants to deliver services to children whose parents are substance abusers, and discretionary grants for research and demonstration projects to identify, prevent, and treat child abuse and neglect. NCCAN awards states several types of grants: basic state grants to develop, strengthen and implement programs to prevent and treat child abuse and neglect; medical neglect/disabled infant grants to respond to reports of medical neglect, particularly, for disabled infants with life-threatening conditions; challenge grants to improve child abuse prevention efforts and establish children's trust funds; and children's justice act grants to improve administrative and judicial handling of child abuse cases.

In our May 1991 testimony, we reported that NCCAN relied on periodic group meetings with grantees to monitor their performance and had made few site visits of the grantees for this purpose. While NCCAN continues to hold these group meetings, it made site visits to 15 (15%) of its 101 discretionary grantees between July and September 1991. Site visits allow NCCAN staff to respond to grantee questions and concerns, provide technical assistance, observe project activities, make preliminary assessments about grantees' performance, and make recommendations for improvement and follow-up.

NCCAN officials stated the site visits also enabled NCCAN staff to develop a background in evaluating grantees and various approaches to performing grant evaluations that NCCAN plans to present at future periodic meetings with grantees. Through the site visits, NCCAN also furthered an evaluation study of NCCAN-funded, comprehensive community demonstration projects. The study aims to ascertain the effectiveness of prevention systems. During the site visits, NCCAN staff assessed the projects to ensure that critical design components were in place in order that the projects' outcomes could be scientifically validated by an independent contractor. These site visits represent NCCAN's first major effort towards evaluating grantees.

In our prior testimony, we expressed a concern that shortages in staff and resources were hindering NCCAN's grant administration activities and preventing NCCAN from complying with related HHS policies. Although NCCAN has completed some on-site reviews and has begun to assess grantees' needs, we still question whether the number of on-site visits is adequate. HHS's Grants Administration Manual (chapter 11, section I), which applies to discretionary grantees, states that on-site visits should be made at least annually to each grantee, subject to the availability of resources. NCCAN visited 3 of its 93 discretionary grantees in 1990 and 15 of its 101 discretionary grantees in 1991. Furthermore, out of the 90 planned visits to various grantees and contractors in 1992, NCCAN plans to visit 2 of the 37 discretionary grantees it has funded so far. The number of visits is well below HHS's guidelines for on-site visits. Thus, staff and budget shortages will continue to limit its effectiveness in monitoring grants during 1992.

In our previous testimony, we reported that NCCAN had neither evaluated the quantity or quality of technical assistance provided nor surveyed the grantees on whether its technical assistance and training are adequate and timely. This has not changed. As part of our ongoing examination of NCCAN's program management, we will be asking the grantees to assess the technical assistance provided by NCCAN to identify ways that it could refocus its effort to better assist its grantees.

CLEARINGHOUSE AND RESOURCE CENTERS

In our previous testimony, we reported that NCCAN was procuring a new contractor[3] to operate the National Clearinghouse on Child Abuse and Neglect and that the procurement process had been reinstituted due to the filing of a bid protest. Since then, NCCAN obtained extensions of the contract from the previous clearinghouse contractor to prevent the disruption of services. The bid protest was resolved and a contractor was procured. To date, NCCAN has moved forward on program initiatives involving the management of the clearinghouse in conjunction with two resource centers, the National Resource Centers on Sexual Abuse and on Child Abuse and Neglect.

NCCAN has significantly increased their budget for the clearinghouse and has maintained a constant level of funding for the resource centers. In 1990, they allocated $540,000 to administer clearinghouse operations, and in 1991, this allocation rose to over $900,000. In 1992, NCCAN has budgeted $850,000 for this operation. The clearinghouse is responsible for disseminating child abuse and neglect information and identifying potentially successful programs. The resource center budgets have remained constant at $400,000 for each of the two resource centers, which are responsible for providing technical assistance on the prevention, identification, and treatment of child abuse and neglect.

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[3] NCCAN procured a contractor to operate two clearinghouses. the National Clearinghouse on Child Abuse and Neglect, which NCCAN manages, and the National Clearinghouse on Family Violence, which is managed by the Office of Community Services.

NCCAN has taken steps to promote closer working relationships between the clearinghouse and the resource centers. These steps have allowed NCCAN to better comply with the clearinghouse CAPTA mandate to disseminate child abuse and neglect information. In November 1991, NCCAN convened a meeting to coordinate resource center and clearinghouse plans. As a result, the clearinghouse and resource centers have agreed to share resources and publicize one another's activities at meetings and conferences. An outcome of this meeting was an increase in the clearinghouse mailing list from 3,805 to over 75,000.

While these efforts have improved the clearinghouse's ability to disseminate information, we question whether the CAPTA requirement that the clearinghouse identify potentially successful programs will be met. For instance, the clearinghouse's primary basis for determining successful programs is final reports produced by the grant recipients themselves. These reports have not been validated. Evaluation information contained in these self-prepared reports may be subject to natural bias. We believe the grant programs should be independently evaluated, so that NCCAN can identify those that are successful and disseminate this information through the clearinghouse. Once this process is completed, successful programs can be highlighted in the clearinghouse's compendium of grant information. We are not sure when NCCAN will be able to accomplish this.

NATIONAL CHILD ABUSE AND NEGLECT DATA SYSTEM (NCANDS)

In our previous testimony, we reported that NCCAN planned to implement a CAPTA-mandated National Child Abuse and Neglect Data System to compile state information on cases of substantiated and unfounded child abuse and neglect and on deaths caused by child abuse and neglect. We reported that the system had been tested in nine states, which were to provide calendar year 1990 summary data to NCCAN in early fiscal year 1992. NCCAN has made progress on this effort, almost completing the collection of 1990 standardized summary data. The states were not required to participate in the national data system, but NCCAN secured the voluntary cooperation of 47 states, one territory, the District of Columbia, and the military services.

NCCAN plans to produce a series of working papers based on the collected data that will be distributed to every state and the clearinghouse by the end of March 1992. NCCAN also plans to test a pilot program for collecting detailed case data. In February, NCCAN began to survey states interested in participating in this more detailed collection effort and plans to incorporate this data collection into the system in 1993. It is too early to tell how effective this will be.

CAPTA-MANDATED REPORTS

In our 1991 testimony, we reported that NCCAN had not submitted six of seven CAPTA-mandated reports to the Congress and that NCCAN said it would issue these reports no later than September 1991. Three of the reports are to examine the incidence of child abuse among handicapped children, alcoholics, and high-risk groups. The other reports are to examine (1) the coordination efforts of agencies and organizations responsible for child abuse and neglect programs and activities, (2) the effectiveness of programs assisted under the Victims of Crime Act, and (3) the relationship between nonpayment of child support and child maltreatment. While the reports have been drafted, they are still under ACYF, ACF, or HHS review. In July 1991, the HHS Chief of Staff notified the Speaker of the House that the reports would be delayed due to the extensive research required and a backlog of reports requiring HHS review. NCCAN could not provide us with a projected issue date for any of these reports.

STAFF AND BUDGET RESOURCES

In May 1991, we reported that NCCAN staffing shortages were hampering NCCAN's ability to manage child abuse and neglect programs. At that time, NCCAN was authorized 21 positions and had 14 full-time staff and 7 unfilled positions. Since then, NCCAN's authorized staffing level has been reduced by 1, to 20 positions. Four of the 20 positions, all for professionals, remain unfilled. The others are filled by 16 permanent staff, 1 of whom is on detail elsewhere. NCCAN is attempting to compensate for the shortfall through the use of three detailees from other agencies and three temporary hires. Although NCCAN was able to hire four professional staff in late 1991, three replaced staff who had left. Despite these additions, NCCAN's staffing levels are still lower than in 1989, when NCCAN had 16 staff, including 14 professionals, to manage a smaller workload.

Earlier we also reported that an Office of Human Development Services' (OHDS) policy prohibited NCCAN from recruiting and hiring from outside OHDS. Today we can report that changes in this policy, adopted in April 1991, have enabled NCCAN to recruit and hire 4 professionals from nationwide Office of Personnel Management registers and added to its professional expertise.

In our previous testimony, we reported that NCCAN used grantees and contractors to provide technical assistance and training. NCCAN continues to use contractors to compensate for staff shortages. For example, NCCAN used a contractor to prepare a summary of final reports submitted by about 25 grantees that is to be disseminated through the clearinghouse. NCCAN's Director said that this function should be performed by NCCAN staff instead of a contractor. This would allow NCCAN to better accomplish its mandate to compile and disseminate meaningful information on child abuse and neglect. Dissemination of NCCAN-developed products also gives NCCAN visibility as a federal leader in preventing and treating child abuse and neglect.

In May 1991, we reported that staff shortages contributed to heavy workloads for NCCAN staff. Staff shortages continue to contribute to heavy workloads. For example, one staff person is responsible for each of the following areas: (1) 108 state grants in 57 states and territories, liaison between NCCAN and 10 ACF regional offices, and legislative expert and researcher; (2) 47 challenge grants; and (3) 42 Children's Justice Act grants. Furthermore, NCCAN officials believe the agency needs at least 10 additional staff with expertise in (1) child protective services, (2) regulatory and legislative research, (3) design and research, (4) planning, (5) statistics, (6) data analysis, (7) technical writing, and (8) chronic neglect research. NCCAN staff also believe they need a deputy director to assist in the management of NCCAN programs and activities.

NCCAN's administrative budget continues to be disproportionately lower than its program budget. In fiscal year 1990, NCCAN received about $750,000 to administer over $39 million in grant programs, and in 1992, was allocated about $945,000 to administer $69.3 million in planned grant programs.

Earlier we reported that NCCAN requested authority to reprogram funds to hire a deputy director in 1991, but during the reorganization of ACF, this request was denied, and recently

NCCAN's staff authorization was reduced. Since NCCAN's grant responsibilities have increased, we believe that NCCAN will continue to be limited in its ability to effectively manage its grant workload.

NCCAN's ROLE IN S. 838

S. 838 would establish a new Child Abuse Treatment Improvements Grant Program aimed at improving the treatment of children exposed to abuse or neglect and their families when such children have been placed in out-of-home care. NCCAN's grant administration responsibilities have increased over several years through successive CAPTA amendments, but its staff resources have not been sufficient to fulfill its responsibilities. If NCCAN is assigned S. 838's grant program, this would be in addition to the six major grant programs it already administers.

NCCAN's Director told us that if assigned responsibility for implementing S. 838's new grant program, NCCAN would attempt to secure additional expertise and would need (1) several additional staff to manage the grants, (2) space for additional staff, and (3) funds for travel to monitor grants. NCCAN told us it could manage the S. 838 grant program in coordination with the Children's Bureau, which is responsible for activities emphasized by S. 838.

Since NCCAN's administrative budget has not kept pace with its increasing program responsibilities, and NCCAN has not been able to meet its CAPTA mandates with its current resources, we question whether NCCAN has the expertise and staff to assume a new grant program. At current resource levels, the additional responsibilities proposed by S. 838 could cause NCCAN to either further reduce its CAPTA grant administration activities or administer the new act less effectively than envisioned by Congress.

CONCLUSIONS

In our May 1991 testimony, we concluded that staff shortages kept NCCAN from fully carrying out its mission and CAPTA requirements and that if NCCAN programs were not given priority attention within the newly formed ACF, the Congress might wish to consider reducing its expectations for NCCAN or seeking other means for achieving CAPTA goals. Since then, NCCAN has made some progress in monitoring grant programs, managing the clearinghouse and resource centers, and obtaining additional staff and expertise. However, despite these encouraging actions, NCCAN's administrative effectiveness may not improve because of NCCAN's substantial and increasing workload. NCCAN continues to fall short in its ability to provide timely on-site monitoring, assess its technical assistance, and submit CAPTA-required reports to the Congress. We believe that NCCAN's limited resources continue to hinder its ability to accomplish its mission to become a leader in child abuse and neglect prevention and treatment.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other members of the Subcommittee may have.

Chairman OWENS. Thank you.

Mr. Davidson.

Mr. DAVIDSON. Good morning. My name is Howard Davidson. I'm an attorney and chairperson of the United States Advisory Board on Child Abuse and Neglect.

This past September, I was elected Chair of the Board, succeeding Dr. Richard Krugman, who testified before you last May. He is a distinguished pediatrician.

Today, you have the opportunity and—I would respectfully add—the responsibility to enact the most effective national child protection legislation in the 20th century.

I believe that a significant member of national child protection experts have come to the same conclusion; namely, that we need a bill that does not merely focus on small parts of the problem, or on one Federal agency, or on one narrow aspect of child maltreatment.

Rather, we need to draw from the collective wisdom of those who work in this field to build the foundation of a comprehensive, child-centered, family-focused, and neighborhood-based child protection system.

Such a system, by including far more emphasis on prevention, evaluation, quality control, and inter-agency coordination, might even save a great deal of the money that is now being drained from scare resources by the present crisis-driven American child protection system.

Awareness of the intent of the problem is there, but we need more than awareness. We need a new direction, and critical to this new direction is a solid and effective leadership, bipartisan leadership on the national level in terms of Federal policy and systemic reform.

Because of the important role of Federal leadership in addressing child maltreatment, the advisory board has presented you and your Congressional colleagues with 54 options for action that were included in its September 1991 report, entitled, "Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect."

These options address a full range of Federal legislative reforms that the Board considers vital if we as a Nation are to help assure the safety of America's children.

Because of the critical role of Federal leadership in the creation of an effective and pro-active national child protection system, it is important that it be clearly understood that my use of the term "Federal leadership" does, of course, include the important role of the National Center on Child Abuse and Neglect.

However—and I cannot stress this enough—Federal leadership must include much, much more than the work of one agency, one Cabinet department, and yes, even one subcommittee.

One of the things that many of us find most frustrating about the bureaucracy of Congress is that many of the most important actions that our board has proposed fall outside of the constricted jurisdiction of this subcommittee, as well as your parent Committee on Education and Labor.

Congressman Owens, you, yourself, said today that the child protection system is outside the scope of your subcommittee's jurisdiction.

The subject of child abuse and the response to it should not be narrowly addressed within one Congressional committee's jurisdiction. But today, unfortunately, that is the reality. To put this another way, if you merely focus on NCCAN and the grant programs historically administered by that agency, you will be doing a great disservice to maltreated children.

You must find a way of getting Congress to address the health, mental health, justice, and education system problems that prevent our Nation from adequately responding to child abuse.

You must find a way of mobilizing the Federal agencies that are responsible for supporting our Nation's health, mental health, justice, and education programs to undertake and institutionalize new child protection initiatives as well as enhancing social service agency responses to the plight of abused, neglected children.

Critically needed reforms will be doomed to failure if legislative revisions merely tinker with CAPTA and NCCAN. And worse, mere tinkering with the law can mislead Americans into thinking that their elected representatives in Washington are doing something significant about child abuse. Today, over a year and a half since our Congressionally-created board declared child abuse and neglect to be a national emergency, hundreds of thousands of American children are still, in the words of the board's first report, being "starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled."

So far, the Federal role in support of America's child protection system has been very weak. As the board has outlined in its 1991 report, the inadequacy of the Federal role has, in effect, contributed substantially to the present emergency and lack of accountability in the Nation's child protection system.

A current case of an abused child from middle America illustrates why you—Democrats and Republicans alike—must find a way to effectively address the inter-disciplinary, inter-agency aspects of child protection.

A few weeks ago, I received a call from a foster mother of a 6-month-old boy who I'll refer to as Bobby. That's not his real name. Shortly after birth, Bobby was severely beaten by his father, resulting in massive brain damage, blindness, and the need for constant medical attention.

Bobby was removed from the home by the police and spent several weeks in the hospital. The county child welfare authorities then placed him in a foster home. Last month, Bobby's father pled guilty to child abuse, and received a shockingly light sentence of 4 years probation.

Worse, the same judge who heard the criminal abuse proceeding, having authority over the child's foster care placement, ordered that Bobby be returned to his father and mother immediately.

Bobby's foster parents were rightfully outraged. The father, they said, even had a history of prior abuse of another child. There was concern that neither the father nor mother had the knowledge to operate the breathing monitor that Bobby required, nor was there enough time to evaluate and treat the parents so that Bobby would be safe.

Why, the foster parents asked me, is there such pressure to have Bobby returned home to such a dangerous situation? Where was the health system's consultation to the court in terms of an evaluation of Bobby's on-going specialized health care needs? Where were the mental health and child development professionals who could effectively assess for the court the capacity of his parents to safely care for Bobby, as well as their potential for further violent outbursts directed against him?

Where was the court system, including a lawyer for Bobby, primarily concerned with protecting his interests? Where were the school personnel who saw, on a daily basis, Bobby's siblings, and might be aware of danger signs affecting other children in this abusive family?

And, finally, where was the Federal leadership and support to this community's professionals, in terms of technical assistance, training, and dissemination of standards of practice.

As far as I can determine, important opportunities were missed to properly equip this community to both prevent Bobby's abuse and to respond to it in a proper inter-disciplinary fashion. Bobby's protection was not a high public priority because, in part, our national child protection system is not truly child-centered.

That system is too often not "protective" at all. And in no sense is our child protection system truly a national one, with established minimum standards for the child protection-related work of social service agencies, mental health programs, physicians and hospitals, attorneys and the courts.

Representative Goodling's testimony before you this morning has rightfully suggested that the lack of standards for training and professional practice has led to a lack of child protection system accountability that has caused the needless suffering of children and parents alike.

America must spell out, at both the Federal and State levels, an adequate statement in our laws detailing the primary purposes of the Nation's child protection program. This is why the board has provided in its 1991 report a proposed National Child Protection Policy focused on the rights of children who have been subjected to abuse and neglect.

Incorporating the board's proposed policy, or elements from it, into CAPTA will give that law a meaning and impact that it has lacked for 18 years. CAPTA is a law that, astonishingly, has never had any "purpose clause" ever incorporated within it.

Let me turn to NCCAN for a moment. In the past year, NCCAN, under the able direction of David Lloyd and Commissioner Wade Horn, has increased its staff, improved the quality of its work, and enhanced its stature within the child protection community nationally.

I wish to reiterate that the Board has found Federal child protection efforts as a whole to be grossly deficient. Therefore, the Board believes that the commissioning of time-consuming, costly, and repetitive studies of NCCAN's operations alone would be a wasteful enterprise which would not result in getting the U.S. Public Health Service, the Department of Education, or the Attorney General of the United States to institutionalize any major child protection policy initiatives.

The Board has said in its 1991 report that Congress should consider assigning NCCAN clear responsibility for Federal leadership and support of the beleaguered State and county child protective services agencies of America. These agencies are in crisis, and many are on the verge of collapse. They are overwhelmed with reports of child abuse and neglect as well as accusations of mismanagement of their child protection caseloads.

Increasingly, these agencies are being sued for inappropriate removal of children from their homes, failure to remove children from dangerous homes, and a lack of services to help strengthen and support families so that children can avoid unnecessary and unnecessarily prolonged foster care placement.

Over the next year, the Board will be studying the issue of national child protective service agency reform. In the interim, there is much that NCCAN could do to help such agencies.

However, as the Board has stated in its 1991 report—and I want to reemphasize now—if Congress wishes NCCAN to assume this responsibility, then Congress must legislatively strengthen NCCAN's capacity, and this action must include assuring that NCCAN has the additional funds and professional staff to do the job adequately.

Merely heaping more responsibilities, more paperwork review, more reports, more studies, and more work on NCCAN, without guaranteeing it the commensurate resources needed, is to continue to set that agency up to fail. In order to improve the programs that NCCAN now supports, the Board believes that the Congress could take the following steps:

Number one, require NCCAN to create standing review panels for all grant and contract proposals submitted to it in order to substantially improve the quality of NCCAN-funded research and demonstration projects.

Number two, require all NCCAN grantees to set aside funds for an independent evaluation component in order that demonstration projects supported by NCCAN be of much greater usefulness nationwide.

Number three, require NCCAN to collect from all the States uniform, case-specific information that is integrated with case-based foster care and adoption data, in order for those who are concerned about child maltreatment to have a better picture of child abuse and neglect in America and the child protection system's response thereto.

Number four, establish a new national incentive program of fellowships and/or scholarships, not just four or five grants to individuals each year but rather, in order to encourage university students pursuing graduate training in medicine, social work, law, and other fields, provide a new grant program, administered through grants to colleges and universities, so that students can be encouraged to work as professionals in the field of child protection.

Number five, require NCCAN, in collaboration with the Public Health Service, the Department of Education, and the Department of Justice to jointly implement such a fellowship program.

And, number six, require the Department of Education to establish, with guidance from NCCAN, a program that activates child protection initiatives in State and local education agencies throughout the Nation.

Since 1974, CAPTA has given NCCAN the authority to distribute millions of dollars to State child protective services agencies that meet certain "eligibility criteria" based on language in the statute and NCCAN's own regulations.

The subcommittee should look carefully at these criteria to see if, (1) some are imposing inappropriate barriers to the effective protection of children—and your question this morning suggests a concern about that, Congressman—and (2) some are not really being implemented as Congress intended.

An example of criteria imposing inappropriate barriers is the criterion requiring confidentiality. In this instance, the NCCAN regulation concerning confidentiality may be inhibiting the necessary inter-agency sharing of vital information about the children and families.

An example of criteria not being implemented as intended is a study that has shown that despite a provision of CAPTA dating back to 1974, all children in child abuse and neglect cases are not promptly receiving court-appointed independent legal representation.

The severely abused infant, Bobby, whom I mentioned earlier, didn't have legal representation, and neither do thousands of maltreated children whose cases are before American courts. Something must be done about that appalling practice.

The Board is aware that the subcommittee, as part of this year's reauthorization of CAPTA, has a particular interest in doing something significant on the subject of child deaths due to abuse and neglect.

This is also a subject that the Board will devote special attention to this year, including an April public hearing in Los Angeles, a meeting with a model inter-agency child fatality review team, and the development of a special issue paper on the topic.

Board members are also distressed, as I know you are, that the Presidential Commission on Child and Youth Deaths, established as part of the 1988 amendments to CAPTA, was never funded by the Congress, and the Commission was never convened by the President.

Since the Board has already decided to carefully study this issue, it would be capable of broadening its work to more fully address this subject, so long as the Board is given the necessary resources to properly fulfill any additional set of duties.

In two consecutive reports, the Board has stressed the critical need to provide home visitation resources for families. Promoting the development of such resources is the single most important step that Congress could take this year regarding the safety and welfare of America's abused and neglected children.

Home visitation is the best documented child maltreatment prevention program. Congress should not bypass this opportunity to help our Nation begin to implement a large series of coordinated pilot home visitation projects.

The Board hopes that the subcommittee members, regardless of political affiliation, share with the Board the goal of transforming our system of child protection in America so that it will become as easy for a parent to pick up the telephone and get help before abuse occurs, as it is now for a neighbor to pick up a telephone and report that parent for abuse.

The planned, sequential implementation of home visitation programs under the leadership of the U.S. Department of Health and Human Services can be initiated by Congressional action, which you can begin to take later today.

The options that the Board has presented to you require prompt and careful attention. Children are being starved, beaten, maimed, and killed by parents who could be helped before the harm occurs.

Just as tragically, once our government agencies identify these children, most receive no treatment at all, and when they do receive treatment, they are often prematurely returned to abusive households. Innocent parents are also being unfairly victimized by a child protection system that is on the verge of collapse.

Members of Congress are rightfully being asked: What are you doing about this national emergency?

For some, the answer has for too long been the support of bills, often labelled with the words "child protection," that only deal with one tiny aspect of the problem of child maltreatment.

Many proposed approaches are not carefully thought out, are simplistic, lack comprehensiveness and a consistency with other related pieces of legislation, or are not backed with adequate funding.

In conclusion, your subcommittee, Congressman, made a conscious decision last year not to be rushed into hastily approving a new national child abuse and neglect law. You were right.

I hope that the time has now come where you will utilize the collective wisdom of those who work in this field to carefully fashion a bill that incorporates a full gamut of meaningful child protection reforms.

If, in order for you to do that, you need to decouple the family violence provisions from the CAPTA reauthorization and move that important spouse abuse protection legislation more speedily, then by all means do so, but don't shortchange the abused and neglected children of America.

Thank you, Mr. Chairman, for your kind words about the Board, and for giving the Board the opportunity to express these views.

We hope that our efforts, like the work done by Federal advisory boards on the problems of the elderly, infant mortality, mental retardation, and AIDS, have been and will continue to be valuable to the Congress, the Executive Branch, and the American people.

I believe that the knowledge and guidance on this complex issue of child maltreatment, provided by our inter-disciplinary bipartisan board of 15 national experts can be an important resource in the years ahead.

Let me respectfully take this opportunity, however, to set the record straight on four points concerning the support of the board and compensation of board members, because Commissioner Horn referenced them in his testimony.

Number one, board members are only compensated for time spent in connection with meetings.

Number two, for each meeting day that board members spend on the average, each of the board members have been putting in an average of three to four additional uncompensated days of time.

Number three, a board member rate of compensation for meeting days is not the $1,000 a day that Commissioner Horn said, but rather $289 a day—big difference.

And, number 4, the Board is unaware of any $200,000 board contract money for this fiscal year.

In closing, all Americans, regardless of political idealogy, should be uniformly committed to finding a way for our Nation to do something significant about the terrible national problem of child abuse and neglect.

Meaningful Congressional action in 1992—not later, in 1992—by Democrats and Republicans alike, can make an immense difference in the lives of millions of children and their families.

Thank you very much for your time.

[The prepared statement of Howard Davidson follows:]

TESTIMONY

OF

HOWARD A. DAVIDSON
CHAIRPERSON
U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

ON

THE 1992 REAUTHORIZATION OF THE

CHILD ABUSE PREVENTION AND TREATMENT ACT

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

COMMITTEE ON EDUCATION AND LABOR

UNITED STATES HOUSE OF REPRESENTATIVES

February 27, 1992

Introduction

My name is Howard Davidson. I am an attorney and Chairperson of the U.S. Advisory Board on Child Abuse and Negloct. This past September I was elected Chair of the Board -- succeeding Dr. Richard Krugman, a distinguished pediatrician, who testified before this Subcommittee last May. I am pleased to have been asked to present the views of the Board on reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), the primary Federal law addressing the shameful maltreatment of our nation's children.

Today, in February 1992, you have the opportunity -- and the responsibility -- to enact the most effective national child protection legislation in the twentieth century. I believe that a significant number of national child protection experts have come to the same conclusion as the Board. Namely, that we need a bill from the House of Representatives that does not merely focus on small parts of the problem -- or on one Federal agency, or on one narrow aspect of child maltreatment.

Rather, we need to draw from the collective wisdom of those who work in this field to build the foundation of a **comprehensive, child-centered, family-focused, and neighborhood-based child protection system**. Such a system -- by including far more emphasis on prevention, evaluation, quality control, and inter-agency coordination -- might even save a great deal of the money that is now being drained from scarce resources by the present crisis-driven American child protection system.

I believe that there is now a tremendous momentum for changing that system. Awareness of the extent of the problem is there. But we need more than awareness. We need a new direction, and critical to this new direction is a solid and effective leadership -- leadership on the national level in terms of Federal policy and systemic reform.

Because of the important role of Federal leadership in addressing child maltreatment, the Board has presented you and your Congressional colleagues with **54 "Options for Action"** that were included in its September, 1991 report entitled "Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect." (A condensed copy of the report's recommendations and the 54 Congressional "Options for Action" is attached to this testimony.) These Options address a full range of Federal legislative reforms that the Board considers vital if we as a nation are to help assure the safety of America's children. The Board expects that the American public will look at how its elected officials use this report in legislative responses to the present crisis in our failing child protective system.

The Need for Mandating a Broad Executive Branch Approach that will Assure Federal Leadership in Child Protection

Because of the critical role of Federal leadership in the creation of an effective and pro-active national child protection system, it is important that it be clearly understood that my use of the term "Federal leadership" does, of course, include the important potential role of the National Center on Child Abuse and Neglect (NCCAN). However -- and I cannot stress this enough -- Federal leadership must include much, much more than the work of one agency, one Cabinet department, or even one Subcommittee.

One of the things that many of us find most frustrating about the bureaucracy of Congress is that many of the most important actions the Board has proposed fall outside of the constricted jurisdiction of this Subcommittee, as well as your parent Committee on Education and Labor. The subject of child abuse -- and the response to it -- should not be narrowly addressed within one Congressional committee's jurisdiction.

To put this another way: If you -- as has the United States Senate -- merely focus on NCCAN, and the grant programs historically administered by that agency, you will be doing a great disservice to maltreated children. You must find a way of getting Congress to address the **health, mental health, justice, and education** system problems that prevent our nation from adequately responding to child abuse. You must find a way of mobilizing the Federal agencies that are responsible for supporting our nation's health, mental health, justice, and education programs to undertake new child protection initiatives, as well as enhancing social service agency responses to the plight of abused and neglected children.

Critically needed reforms will be doomed to failure if legislative revisions merely tinker with CAPTA. And worse, mere tinkering with the law can **mislead** Americans into thinking that their elected representatives in Washington are **doing something significant** about child abuse. Today, over a year and a half since our Congressionally-created Board declared child abuse and neglect to be "a national emergency," hundreds of thousands of American children are still (in the words of the Board's first report) being "starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled."

So far, the Federal role in support of America's child protection system has been very weak. As the Board has outlined in its 1991 report, the inadequacy of the Federal role has, in effect, contributed substantially to the present emergency in the nation's child protection system.

A current case of an abused child from middle-America illustrates why you **must** find a way to effectively address the inter-disciplinary, inter-agency aspects of child protection. A few weeks ago, I received a call from a foster mother of a six-month old boy who I will refer to as Bobby (not his real name). Shortly after birth Bobby was severely beaten by his father -- resulting in massive brain damage, blindness, and the need for constant medical attention. Bobby was removed from home by the police and spent several weeks in the hospital. The county child welfare authorities then placed him in a foster home. Last month, Bobby's father pled guilty to child abuse, and received a shockingly light sentence of four years probation.

Worse, the same judge who heard the criminal abuse proceeding -- having authority over the child's foster care placement -- ordered that Bobby be returned to his father and mother immediately. Bobby's foster parents were rightfully outraged. The father, they said, even had a history of prior abuse of another child. There was concern that neither the father nor mother had the knowledge to operate the breathing monitor that Bobby required, nor was there enough time to evaluate and treat the parents so that Bobby would be safe. Why, the foster parents asked me, is there such pressure to have Bobby returned home to such a dangerous situation?

Where was the health system's consultation to the court in terms of an evaluation of Bobby's on-going specialized health care needs? Where were the mental health and child development professionals who could effectively assess for the court the capacity of his parents to safely care for Bobby, as well as their potential for further violent outbursts directed against him? Where was a court system, including a lawyer for Bobby, primarily concerned with protecting his interests? Where were the school personnel who saw, on a daily basis, Bobby's siblings and might be aware of danger signs affecting other children in this abusive family? Finally, where was the Federal leadership and support to this community's professionals, in terms of technical assistance, training, and dissemination of standards of practice?

As far as I can determine, important opportunities were missed to properly equip this community to both prevent Bobby's abuse and to respond to it in a proper inter-disciplinary fashion. Bobby's protection was not a high public priority because, in part, our national child protection system is not truly child-centered. That system is too often not "protective" at all. And in no sense is our child protection system truly a "national" one, with established minimum standards for the child protection-related work of social service agencies, mental health programs, physicians and hospitals, attorneys, and the courts.

America must spell out, at both the Federal and State levels, an adequate statement in our laws detailing the primary purposes of the nation's child protection program. This is why the Board has provided, in its 1991 report, a "Proposed National Child Protection Policy" focused on the rights of children who have been subjected to abuse and neglect.

Incorporating the Board's proposed Policy, or elements from it, into CAPTA will give that law a meaning and impact that it has lacked for eighteen years. CAPTA is a law that, astonishingly, has never had any "purpose clause" ever incorporated within it.

The Proper Congressional Focus on NCCAN

In its 1991 report, the Board devoted dozens of pages to the strengths and weaknesses of NCCAN and the various grant programs that it administers. In the past year, NCCAN -- under the able direction of David Lloyd and Commissioner Wade Horn -- has increased its staff, improved the quality of its work, and enhanced its stature within the child protection community nationally.

I wish to reiterate that the Board has found Federal child protection efforts **as a whole** to be grossly deficient. Therefore, the Board believes that the commissioning of time-consuming, costly, and repetitive studies of NCCAN's operations alone would be a wasteful enterprise which would not result in getting the U.S. Public Health Service, the Department of Education, or the Attorney General to institutionalize any major child protection policy initiatives.

The Board has said in its 1991 report that Congress should consider assigning NCCAN clear responsibility for Federal leadership and support of the beleaguered State and County child protective services agencies of America. These agencies are in crisis, and many are on the verge of collapse. They are overwhelmed with reports of child abuse and neglect as well as accusations of mismanagement of their child protection caseloads. Increasingly, these agencies are being sued for inappropriate removal of children from their homes, failure to remove children from dangerous homes, and a lack of services to help strengthen and support families so that children can avoid unnecessary and unnecessarily prolonged foster care placement.

Over the next year, the Board will be studying the issue of national child protective service agency reform. In the interim, there is much that NCCAN could do to help such agencies. However, as the Board has stated in its 1991 report and wants to reemphasize, if Congress wishes NCCAN to assume this responsibility, then Congress must legislatively strengthen NCCAN's capacity, and this action must include assuring that NCCAN has the additional funds and professional staff to do the job adequately. Merely heaping more responsibilities, more studies, and more work on NCCAN -- without guaranteeing it the commensurate resources needed -- is to continue to set that agency up to fail.

In order to improve the programs that NCCAN now supports, the Board believes that the Congress could take the following steps:

- Require NCCAN to create standing review panels for all grant and contract proposals submitted to it in order to substantially improve the quality of NCCAN-funded research and demonstration projects.
- Require all NCCAN grantees to set aside funds for an independent evaluation component in order that demonstration projects supported by NCCAN be of much greater usefulness nationwide.
- Require NCCAN to collect from all the States uniform, case-specific information that is integrated with case-based foster care and adoption data in order for those who are concerned about child maltreatment to have a better picture of child abuse and neglect in America, and the child protection system's response thereto.
- Establish a new national incentive program of fellowships and/or scholarships in order to encourage university students pursuing graduate training in medicine, social work, law, and other fields to work in the field of child protection.
- Require NCCAN, in collaboration with the Public Health Service, the Department of Education, and the Department of Justice to jointly implement such a program.
- Require the Department of Education to establish, with guidance from NCCAN, a program that activates child protection initiatives in State and Local Education Agencies throughout the nation.

Since 1974 CAPTA has given NCCAN the authority to distribute millions of dollars to State child protective services agencies that meet certain "eligibility criteria" based on language in the statute and NCCAN's own regulations. The Subcommittee should look carefully at these criteria to see if: (1) some are imposing inappropriate barriers to the effective protection of children, and (2) some are not really being implemented as Congress intended.

An example of criteria imposing inappropriate barriers is the criterion requiring confidentiality. In this instance, the NCCAN regulation concerning confidentiality may inhibit the necessary inter-agency sharing of vital information about the child and family.

An example of criteria not being implemented as intended is a study that has shown that despite a provision of CAPTA dating back to 1974, all children in child abuse and neglect cases are not promptly receiving court-appointed independent legal representation. The severely abused infant whom I mentioned earlier didn't have legal representation, and neither do thousands of maltreated children whose cases are before American courts. Something must be done about this appalling practice.

Child Maltreatment Fatalities: The Ultimate Consequence of Child Protection System Breakdown

The Board is aware that the Subcommittee, as part of this year's re-authorization of CAPTA, has a particular interest in doing something significant on the subject of child deaths due to abuse and neglect. This is also a subject that the Board will devote special attention to this year, including an April public hearing in Los Angeles, a meeting with a model inter-agency child fatality review team, and the development of a special issue paper on the topic.

Board members are also distressed, as I am sure you are, that the Presidential Commission on Child and Youth Deaths, established as part of the 1988 amendments to CAPTA, was never funded by the Congress, and the Commission was never convened by the President. The Board has been approached by Subcommittee staff concerning their interest in having the Board assume additional responsibilities related to child maltreatment fatalities. Since the Board has already decided to carefully study this issue, it would be capable of broadening its work to address the full gamut of the Subcommittee's concerns related to this subject, so long as the Board is given the necessary resources to properly fulfill this additional set of duties.

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Amending CAPTA to Promote Home Visitation Services

In two reports, the Board has stressed the critical need to provide home visitation resources for families. Promoting the development of such resources is the single most important step that Congress could take this year regarding the safety and welfare of America's abused and neglected children. Home visitation is the best documented child maltreatment prevention program. Congress should not bypass this opportunity to help our nation begin to implement a large series of coordinated pilot home visitation projects.

The Board hopes that the Subcommittee shares with the Board the goal of transforming our system of child protection in America so that it will become as easy for a parent to pick up a telephone to get help -- before abuse occurs -- as it is now for a neighbor to pick up a telephone and report that parent for abuse. The planned, sequential implementation of home visitation programs under the leadership of the U.S. Department of Health and Human Services can be initiated by Congressional action. The ball, as they say, is in your court.

Conclusion

The options that the Board has presented to Congress require prompt and careful attention. Children are being starved, beaten, maimed, and killed by parents who could be helped before the harm occurs. Just as tragically, once our government agencies identify these children, most receive no treatment at all, and when they do receive treatment they are often prematurely returned to abusive households.

Members of Congress are rightfully being asked: What are you doing about this national emergency? For some, the answer has for too long been the support of bills -- often labelled with the words "Child Protection" -- that only deal with one tiny aspect of the problem of child maltreatment. Many proposed approaches are not carefully thought out, are simplistic, lack comprehensiveness and a consistency with other related pieces of legislation, or are not backed with adequate funding.

Your Subcommittee made a conscious decision last year not to be **rushed** into hastily approving a new national child abuse and neglect law. You were right. I hope that the time has now come where you will utilize the collective wisdom of those who work in this field to carefully fashion a bill that incorporates a full gamut of meaningful child protection reforms.

Thank you for giving the Board the opportunity to express these views. We hope that our efforts -- like the work done by Federal advisory bodies on problems of the elderly, infant mortality, mental retardation, and AIDS -- have been, and will continue to be, valuable to the Congress, the Executive Branch, and the American people. I believe that the knowledge and guidance on this complex issue of child maltreatment, provided by our interdisciplinary Board of fifteen national experts, can be an important resource in the years ahead.

All Americans, regardless of political affiliation or ideology, should be uniformly committed to finding a way for our nation to do something significant about the terrible national problem of child abuse and neglect. Meaningful Congressional action in 1992 by Democrats and Republicans alike can make an immense difference in the lives of millions of children and their families.

ATTACHMENT

List of Recommendations and Congressional Options for Action in the 1991 Report of the U.S. Advisory Board on Child Abuse and Neglect

Developing and Implementing a National Child Protection Policy

RECOMMENDATION B-1: PROMULGATING A NATIONAL CHILD PROTECTION POLICY

The Federal Government should establish a national child protection policy. The goal of the policy should be to facilitate comprehensive community efforts to ensure the safe and healthy development of children and youth. The policy should be incorporated into the United States Code as an intrinsic part of the Child Abuse Prevention and Treatment Act. The policy should drive the child protection-related actions of all Federal agencies.

Congressional Options for Action

1. Use the next CAPTA reauthorization to enact a national child protection policy.

RECOMMENDATION B-2: RELATING A NATIONAL CHILD PROTECTION POLICY TO POLICY REFORMS IN CHILD WELFARE SERVICES AND FAMILY RESOURCE AND SUPPORT SERVICES

The Federal Government should assist in building a supportive service delivery system for all families, troubled or otherwise, thereby providing a critical foundation for the prevention of child maltreatment and the protection of children. To the extent possible, any statutory or regulatory reforms of the child protection system should be sensitive to and harmonized with the purposes and content of statutory or regulatory reforms of child welfare services and family.

Congressional Options for Action

2. Enact legislation to reform child welfare and family resource and support services. Two bills introduced in the 102nd Congress, S. 4 and H.R. 2571, amended appropriately so that they are harmonized with the national child protection policy described in Recommendations B-1, are likely vehicles.
3. Appropriate necessary funds so that full implementation of the Young Americans Act of 1990 can begin.

RECOMMENDATION B-3: ELIMINATING THE USE OF CORPORAL PUNISHMENT IN ACTIVITIES SUPPORTED WITH FEDERAL FUNDS

Consonant with the intent of the National Child Protection Policy proposed by the Board, the Federal Government should take all necessary steps to eliminate the use of corporal punishment in all activities, programs, institutions, and facilities which receive Federal financial support of any kind.

Congressional Options for Action

4. Enact legislation to prohibit the use of corporal punishment in all activities, programs, and facilities receiving Federal financial assistance.
5. Enact legislation to prohibit the use of corporal punishment in all school systems receiving Federal financial assistance.

RECOMMENDATION B-4: DETERMINING THE COST OF IMPLEMENTING A NATIONAL CHILD PROTECTION POLICY

An appropriate Federal research agency should be commissioned to determine the cost of implementing a national child protection policy and the cost of not implementing such a policy.

Congressional Options for Action

6. *CONGRESSIONAL SUBCOMMITTEES WITH JURISDICTION OVER CAPTA:* Communicate to the Office of Technology Assessment the need for a study to determine the cost of implementing a national child protection policy and the cost of not implementing such a policy.

Preventing and Reducing Child Maltreatment by Strengthening Neighborhoods and Families

RECOMMENDATION C-1: IMPROVING THE QUALITY OF DETERIORATING NEIGHBORHOOD ENVIRONMENTS

The Federal Government should take all steps necessary to facilitate the development of neighborhood improvement initiatives to prevent child maltreatment, including neighborhoods in urban, rural, and Native American communities.

Congressional Options for Action

7. *HEADS OF RELEVANT CABINET-LEVEL AGENCIES AND CONGRESS:* Develop child maltreatment-related and family strengthening activities in rural communities, especially those with a high proportion of families in poverty. The Area Development Districts in the various Federal economic development programs may provide avenues for rural community planning to protect children. Where targeted programs for rural community planning do not exist in a given region, Community Action Programs may be the avenue for planning and implementation of neighborhood-based strategies in rural communities.
8. Require recipients of Community Development Block Grants to set aside five percent of such funds for the purposes of (a) planning and implementing neighborhood-based strategies for strengthening families and the prevention and treatment of child abuse and neglect and (b) the integration of housing programs and child protection efforts. Increase the authorization and appropriations for the Community Development Block Grant Program commensurately.

RECOMMENDATION C-2: ENHANCING VOLUNTEER EFFORTS FOR THE PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT

The Federal Government should take all steps necessary to facilitate the development of volunteer programs for the prevention and treatment of child abuse and neglect.

Congressional Options for Action

9. Establish a new program priority on child maltreatment within relevant programs of ACTION and provide additional funding for this purpose.
10. Amend Serve-America to provide support for school volunteer programs aimed at the (1) prevention of child maltreatment, (2) provision of social supports for maltreated children and their families, and (3) development of additional peer counseling and peer mediation services. This amendment would complement existing emphases in Serve-America on substance abuse prevention and school drop-out prevention.
11. Specifically charge the Cooperative Extension Service to give a greater focus to child maltreatment-related activities (including prevention) and provide additional funds for it to do so.

Providing a New Focus on Child Abuse and Neglect and Strengthening Families in All Relevant Federal Agencies

The Collective Federal Effort

RECOMMENDATION D-1: REDEFINING THE MISSION OF THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

The Federal Government should redefine the mission of the National Center on Child Abuse and Neglect so that the exclusive focus of the agency becomes either: (1) providing leadership for all Federal efforts to strengthen the State and local CPS function; or (2) planning and coordinating the entire Federal child protection effort. Either choice necessarily entails restructuring the agency and moving it to another location within the Executive Branch; either choice probably means renaming the agency. Whichever choice for the redefinition of the National Center's mission is made [(1) or (2) above], a program to carry out the focus not chosen must also be established.

Congressional Options for Action

12. *CONGRESSIONAL SUBCOMMITTEES WITH JURISDICTION OVER CAPTA*: Hold hearings on the appropriate mission of NCCAN and develop amendments to CAPTA reflecting the conclusions reached as a result of those hearings.

RECOMMENDATION D-1: ASSURING A FOCUS ON CHILD MALTREATMENT AND STRENGTHENING FAMILIES THROUGHOUT THE FEDERAL GOVERNMENT

The administrators of all Federal agencies operating programs which are or could be relevant to addressing one or more aspects of child abuse and neglect should ensure that those programs are capable of making full, meaningful, measurable, and visible contributions to the total Federal effort.

Congressional Options for Action

13. *SPEAKER OF THE HOUSE OF REPRESENTATIVES; PRESIDENT PRO TEMPORE OF THE SENATE; MAJORITY AND MINORITY LEADERSHIP OF BOTH CHAMBERS OF CONGRESS*: Convene meetings of the Chairs and their Minority counterparts for all Committees and Subcommittees with jurisdiction over any Federal programs that are, or could be, relevant to the total Federal effort. The purpose of these meetings would be to devise a legislative strategy for assuring a focus throughout the Federal Government on strengthening families and preventing and treating child maltreatment. Such a strategy might involve the drafting and introduction of a "chain bill" that links the various Federal programs in a common approach to the problem of child maltreatment.

Child Protection and the Child Welfare System

RECOMMENDATION D-2: STRENGTHENING CHILD PROTECTION EFFORTS IN THE CHILD WELFARE SYSTEM

The Federal Government should take all necessary measures to ensure that, within the nation's system of public social services, State, Tribal, and local CPS agencies deliver high quality services. These measures should include knowledge building, program development, program evaluation, data collection, training, and technical assistance on:

- ***the development of linkages with other service providers and community resources to ensure that children and families are receiving coordinated, integrated services;***
- ***the development of a focus on prevention and early intervention with high-risk families;***
- ***the prompt, thorough, and family-sensitive investigation of cases of suspected maltreatment;***
- ***the appropriate use of risk assessment in cases of suspected or substantiated child abuse and neglect;***
- ***the assessment and management of such cases (including in-home crisis services and other services designed to increase children's safety, strengthen families in crisis, and prevent unnecessary out-of-home placements);***
- ***the relationship of CPS to respite and other out-of-home care for the purpose of child protection; and***
- ***the relationship of CPS to permanency planning and adoption services for children who have been removed from their families due to maltreatment.***

Congressional Options for Action

14. Statutorily assign NCCAN clear responsibility for Federal leadership with regard to the CPS function, but, in doing so, legislatively strengthen NCCAN's capacity to assume that responsibility.

Child Protection and the Mental Health System

RECOMMENDATION D-3a: STRENGTHENING CHILD PROTECTION EFFORTS IN THE MENTAL HEALTH SYSTEM

The Federal Government should take all steps necessary to ensure (a) that effective mental health treatment is available and accessible to abused and neglected children and their families (including biological, adoptive, and foster families) and (b) that mental health programs for children and families collaborate with other agencies and community groups in the prevention of child maltreatment.

Congressional Options for Action

- To stimulate capacity-building efforts:
    15. Require recipients of grants under the Alcohol, Drug Abuse, and Mental Health Block Grant to set aside an appropriate percentage of such funds for community-based mental health services for abused and neglected children and their families and for programs to prevent child maltreatment among families at risk. If such an action is taken, the Block Grant should be increased by a commensurate amount, and grantees should be required to demonstrate their collaboration with health, social service, and justice agencies, as well as private non-profit voluntary organizations.

16. Establish a new formula grant program for such a purpose. Such a grant program could be directed (1) to State mental health or health agencies (as designated by the Governors) for competitive distribution to community agencies, or (2) directly to community mental health or health centers (as designated by the Governors).

- To increase the involvement of the mental health system in child protection:

17. Statutorily mandate the establishment of such a unit.

- To decrease real or perceived obstacles to use of existing financing systems for effective mental health services related to child abuse and neglect, including treatment of State wards:

18. *CHAIRPERSON AND RANKING MINORITY MEMBER OF THE HOUSE WAYS AND MEANS COMMITTEE; CHAIRPERSON AND RANKING MINORITY MEMBER OF THE SENATE FINANCE COMMITTEE*: Request that the General Accounting Office or the Office of Technology Assessment conduct such a study. Congress could further take any legislative action, including use of its oversight authority, necessary to eliminate such obstacles.

- To improve the quality of mental health services related to child abuse and neglect:

19. Authorize and appropriate funds for such purposes.

RECOMMENDATION D-3b: ADDRESSING THE CONNECTION BETWEEN SUBSTANCE ABUSE AND CHILD MALTREATMENT

The Federal Government should take all steps necessary to ensure that substance abusing parents have access to both effective programs for the prevention and treatment of child abuse and neglect as well as substance abuse itself. To be effective, Federal efforts must include initiatives to increase (1) the availability and accessibility of prevention and treatment programs and (2) knowledge about the relationship between substance abuse and child maltreatment, including the effects of various policies and programs designed to prevent children's pre- and postnatal exposure to alcohol and other harmful drugs.

Congressional Options for Action

- To increase the availability and accessibility of prevention and treatment programs for substance abusing parents:

20. Require recipients of grants under the Alcohol, Drug Abuse, and Mental Health Block Grant to set aside an appropriate percentage of such funds for community-based services aimed at the prevention and treatment of child maltreatment resulting from or complicated by substance abuse. Staff providing such services, including staff providing services to Native Americans, should include degreed mental health specialists, paraprofessionals, and volunteers.
21. Statutorily mandate the establishment of a new formula grant program for this purpose.
22. Statutorily mandate the establishment of a new demonstration grant program and/or expansion of existing programs for this purpose.

- To enhance the state-of-the-art in the prevention of children's pre- and postnatal exposure to alcohol and other harmful drugs and to treat the effects of such exposure:

23. Statutorily require the Executive Branch to take the steps set forth above.

Child Protection and the Schools

RECOMMENDATION D-4a: STRENGTHENING THE ROLE OF ELEMENTARY AND SECONDARY SCHOOLS IN THE PROTECTION OF CHILDREN

The Federal Government should take all necessary measures to ensure that the nation's elementary and secondary schools, both public and private, participate more effectively in the prevention, identification, and treatment of child abuse and neglect. Such measures should include knowledge building, program development, program evaluation, data collection, training, and technical assistance. The objective of such measures should be the development and implementation by State Educational Agencies (SEAs) in association with Local Educational Agencies (LEAs) and consortia of LEAs, of:

- ***inter-agency multidisciplinary training for teachers, counsellors, and administrative personnel on child abuse and neglect;***
- ***specialized training for school health and mental health personnel on the treatment of child abuse and neglect;***
- ***school-based, inter-agency, multidisciplinary supportive services for families in which child abuse or neglect is known to have occurred or where children are at high risk of maltreatment, including self-help groups for students and parents of students;***
- ***family life education, including parenting skills and home visits, for students and/or parents; and***
- ***other school-based inter-agency, multidisciplinary programs intended to strengthen families and support children who may have been subjected to maltreatment, including school-based family resource centers and after-school programs for elementary and secondary school pupils which promote collaboration between schools and public and private community agencies in child protection.***

Congressional Options for Action

24. Establish a program of grants for the development and implementation of school-based efforts to address child maltreatment. Funds would be allocated by formula to SEAs which would then distribute them competitively to LEAs and consortia of LEAs. SEAs would retain a limited percentage of funds for the cost of providing technical assistance to LEAs and consortia of LEAs and for statewide inter-agency multidisciplinary training of school personnel. This program would be administered by the Department of Education, in collaboration with DHHS, or vice versa. Program collaboration should also include, where applicable, Bureau of Indian Affairs-operated schools.
25. Establish a program of grants for the development and implementation of public-private school-based efforts which focus on bringing community resources and services--including child care centers for teen mothers as well as relevant parent support/education services--into the schools to serve at-risk children and their families.
26. Establish a program of special grants for the employment of psychologists and social workers (including masters-level psychologists and social workers) by schools in rural areas heavily populated by Native American children as well as on reservations for the purpose of providing treatment services to maltreated children.

RECOMMENDATION D-4b: ENHANCING FAMILY LIFE EDUCATION OPPORTUNITIES FOR ADOLESCENTS AND YOUNG ADULTS TO PREPARE FOR RESPONSIBLE PARENTHOOD

The Federal Government should stimulate new family life education initiatives specifically aimed at adolescents and young adults which have as their underlying purpose the prevention of child maltreatment.

Congressional Options for Action

27. Specifically charge the Cooperative Extension Service to give a greater focus to child maltreatment-related activities (including prevention) and provide additional funds for it to do so.

Child Protection and Health

RECOMMENDATION D-5: STRENGTHENING THE ROLE OF THE HEALTH SYSTEM IN THE PROTECTION OF CHILDREN

The Federal Government should take all necessary measures to ensure that the nation's health care system plays a more effective role in the prevention and treatment of child abuse and neglect. Such measures should encompass knowledge building, program development, program evaluation, data collection, training, and technical assistance on the role of the health system in the prevention, identification, investigation, and treatment of child abuse and neglect. In planning for involvement of the health care system in child protection, attention should focus on the roles of community health centers, public health authorities (including visiting nurse programs), general and pediatric hospitals, primary health care providers, self-help support networks, and alternative health delivery systems. Federal programs potentially involved in child maltreatment include the National Institute on Child Health and Development, the National Center on Nursing Research, the Center for Health Services Research, the Centers for Disease Control, the Health Care Financing Administration, the Office of Rural Health Policy, and the direct-service programs of the Public Health Service including the Indian Health Service. All of these agencies should participate in the design and implementation of the new effort. In addition, attention should be given to reducing the prevalence of child maltreatment among children with disabilities, amelioration of the health consequences of child maltreatment, and provision for coordinated responses to child maltreatment fatalities.

Congressional Options for Action

28. Statutorily require the Executive Branch to take the steps set forth above.

Child Protection and the Justice System

RECOMMENDATION D-6: STRENGTHENING CHILD PROTECTION IN THE JUSTICE SYSTEM

The Federal Government should take all necessary measures to ensure that the nation's courts, attorneys, law enforcement agencies, probation departments, parole agencies, and correctional institutions provide a prompt, sensitive protective response to all forms of child maltreatment. Such a response should involve knowledge building, program development, program evaluation, data collection, training, and technical assistance aimed at improving the administration of civil and criminal justice related to child maltreatment, advocacy on behalf of maltreated children, treatment for and monitoring of offenders both in communities and correctional settings. The response should be reflected in improved handling of child protection cases by:

- ***Federal, State, and Tribal judges and other court personnel handling civil and criminal cases related to child maltreatment;***
- ***attorneys involved in child maltreatment cases, both civil and criminal, including prosecutors, lawyers representing CPS agencies, court-appointed counsel and guardians ad litem for children, attorneys representing parents, as well as volunteer lay advocates (court appointed special advocates);***
- ***law enforcement personnel involved in the investigation of child maltreatment cases;***
- ***probation and parole officers involved in the supervision of juvenile and adult offenders in cases of child maltreatment; and***
- ***administrators and staff of Federal, State, Tribal, and County correctional institutions where offenders in child maltreatment cases are confined.***

The response should ensure that cases involving allegations of child maltreatment in family settings, in the community, and within residential institutions are all given an adequate focus.

Congressional Options for Action

29. Direct the Department of Justice to develop a planned and coordinated focus for all justice system activities related to child maltreatment, and authorize and appropriate funds for this purpose. This focus should include but not be limited to the activities of: the Criminal Division; the Office of Justice Programs; the Federal Bureau of Investigation; the Executive Office of the U.S. Attorneys; the Administrative Office of the U.S. Courts; the Federal Judicial Center; the State Justice Institute; the Immigration and Naturalization Service; the National Institute of Corrections; and the Bureau of Prisons.
30. Mandate, as part of the reauthorization of, or amendments to, Federal crime and juvenile justice legislation, a new program of research and demonstration grants focused on the improvement of treatment for juvenile and adult offenders in cases of child physical and sexual abuse, both as part of the probationary period and within correctional facilities.
31. Mandate, as part of the reauthorization of juvenile justice legislation, a new program focus on the improvement of legal representation provided to all children in the nation's juvenile and family courts.

Funding Child Protection Efforts

RECOMMENDATION D-7: PROVIDING ADEQUATE FUNDING FOR THE NEW SPECIALLY TARGETED EFFORTS

For each new specially targeted effort recommended in this report, Congress should authorize and appropriate an amount necessary to implement the effort at a reasonable level.

Congressional Options for Action

32. Reallocate existing resources for child welfare services from a focus on supporting the costs of out-of-home placement to a focus on preventive, "front-end," intensive and comprehensive services, including home-based services.
33. In providing any new funding for child protection, establish a formula that, whenever feasible, takes into account the size of the child population, the proportion of that population living in poverty, and the proportion of that population that is homeless.

Staffing Child Protection Efforts

RECOMMENDATION D-8: ASSURING ADEQUATE STAFFING FOR THE NEW SPECIALLY TARGETED EFFORTS

For each new specially targeted effort recommended in this report, all program staff, excluding clerical and grants management staff, should have demonstrated professional competence in the field of child abuse and neglect. Moreover, program staff should possess at least those professional credentials generally recognized as necessary for competent practice or research in their disciplines. The number of program staff and the support available to those staff, including funds for travel, should be sufficient to fulfill their technical assistance mission and to achieve the visibility necessary for national leadership in the various disciplines in the child protection field.

Congressional Options for Action

34. Authorize Executive Branch agencies administering child abuse and neglect related programs, including those under CAPTA, to set aside up to 10 per cent of funds appropriated for those programs for Federal administration of those programs (comparable to the authority provided by Congress in the Young Americans Act). The authorization should require the agencies, before using set-aside funds, to spend from their salaries and expenses appropriations no less than the amount they are currently spending for administration of those programs.

Enhancing Federal Efforts Related to the Generation, Application, and Diffusion of Knowledge Concerning Child Protection

Need for More and Better Knowledge

RECOMMENDATION E-1a: IMPROVING THE COLLECTION OF DATA

The Federal Government should create a comprehensive, mandatory, 50-State and Tribal, aggregate and case-specific child abuse and neglect data collection system. This system should be administered collaboratively by several Federal agencies. In total, it should yield an accurate, uninterrupted, comprehensive picture of child abuse and neglect, as well as the response to it, throughout the nation.

Congressional Options for Action

35. Use the next CAPTA reauthorization to enact the statutory authority for a new data collection system--sensitive to the protection of confidentiality--designed and implemented by the Bureau of the Census in coordination with other data-gathering agencies and include in that legislation authority to provide necessary financial assistance to States and Tribes so that they can develop or enhance their capacity to collect and report data in a manner consistent with Federal standards.

RECOMMENDATION E-1b: IMPROVING FEDERALLY-SUPPORTED RESEARCH

The Federal Government should take all steps necessary to promote systematic research related to child abuse and neglect. Such steps should include:

- ***establishing a new program within the National Institute of Mental Health (NIMH) as the primary Federal research effort concerned with the causes, precipitants, consequences, prevention, and treatment of child abuse and neglect;***
- ***vesting responsibility in that program for the provision of Government-wide leadership concerning research;***
- ***substantially increasing funds available for research in all relevant agencies;***
- ***launching initiatives to increase the number and professional qualifications of scientists involved in studies of child abuse and neglect;***
- ***making peer review and grants management in all relevant agencies consistent with scientific norms;***
- ***engaging in long-range Government-wide planning for stimulation of knowledge on critical topics related to child maltreatment (including cultural and social factors); and***
- ***when feasible, developing means for reducing obstacles to the generation of knowledge about child abuse and neglect.***

Congressional Options for Action

- To increase general knowledge about the causes, precipitants, consequences, prevention, and treatment of child abuse and neglect:
  36. Using the next CAPTA reauthorization, amend the Public Health Act to provide the statutory authority for such a Center and, following authorization, appropriate adequate funds for its activities.

- To increase knowledge about the child protection system:
  37. Statutorily mandate the establishment of such programs or priorities.

- To increase human resources in the field of research on child abuse and neglect:
  38. Amend the Public Health Service Act to mandate the set-aside of funds allocated under the National Research Service Award program and other NIMH programs for research training and career development related to child abuse and neglect.

- To ensure that procedures for stimulation and analysis of research on child abuse and neglect are scientifically credible:
  39. Statutorily mandate that such action be taken.

- To facilitate the planning of research:
  40. Statutorily mandate that such action be taken.

- To reduce obstacles to the generation of knowledge about child abuse and neglect:
  41. Using the next CAPTA reauthorization, amend the Public Health Act to clarify the scope of confidentiality certificates.

RECOMMENDATION E-1c: IMPROVING THE EVALUATION OF PROGRAMS

The Federal Government should ensure that child protection activities supported with Federal funds are subjected to rigorous evaluation and that findings of such studies are applied in the design and implementation of programs in the child protection system.

Congressional Options for Action

42. Use the next CAPTA reauthorization to mandate that recipients of all Federal funds related to any aspect of child protection set aside an appropriate percentage of such funds for evaluation research.

Need for More Skilled Professional Staff

RECOMMENDATION E-2: INCREASING THE QUALIFICATIONS AND NUMBERS OF PROFESSIONALS IN CHILD PROTECTION

The Federal Government should significantly increase incentives and grant programs to expand the numbers and qualifications of professionals available to work in the child protection system.

Congressional Options for Action

43. Use the next CAPTA reauthorization to legislate a new program of incentives through grants/loans to university students in return for work in the field of child protection, similar to the National Health Service Corps Program.

Need for Implementation of Standards of Practice

RECOMMENDATION E-3: DEVELOPING AND IMPLEMENTING STANDARDS OF PRACTICE

The Federal Government should take all necessary measures to ensure that each Federal agency directly providing services in the child protection system (e.g., the Indian Health Service, the Bureau of Indian Affairs, the family advocacy programs in the military, the U.S. Attorneys, and the military courts) meets standards of competent practice, including but not limited to standards for:

- ***staff qualifications and training;***
- ***staff-to-client ratios;***
- ***timeliness of response;***
- ***protection of client rights;***
- ***legal representation of all parties (including the child) in relevant judicial proceedings;***
- ***cultural competence; and***
- ***quality assurance.***

The first of these measures should be commissioning the development of national standards of competent practice for the various professionals and agencies involved in child protection cases at the State, Tribal, and local levels.

Congressional Options for Action

44. Use the next CAPTA reauthorization to mandate individual Federal agencies, especially the Bureau of Indian Affairs, to develop appropriate standards of practice in child protection cases by a date certain.

Need for the Provision of Technical Assistance to State and Tribal Child Protection Efforts

RECOMMENDATION E-4: ESTABLISHING STATE AND REGIONAL RESOURCE CENTERS

The Federal Government should establish a mechanism to stimulate development of State or regional resource centers for training, consultation, policy analysis, and research in the field of child protection. Such centers should be interdisciplinary and should involve collaboration between universities and relevant State and Tribal agencies, including opportunities for university-based sabbaticals for senior State and Tribal officials and agency-based sabbaticals for university professors.

Congressional Options for Action

45. Use the next CAPTA reauthorization to authorize a $50 million nationwide network of State and Regional Resource Centers and, following the authorization, appropriate funds for implementation.

Need for the Diffusion of Knowledge

RECOMMENDATION E-5: IMPROVING THE FLOW OF INFORMATION

The Federal Government should develop a highly visible entity that takes whatever steps are necessary to ensure that practitioners, policymakers, and the general public (especially parents) have ready and continuous access to comprehensive, state-of-the-art information on child abuse and neglect.

Congressional Options for Action

46. Use the next CAPTA reauthorization to mandate the establishment of a permanent information diffusion entity within a component of the Department.

Improving Coordination among Federal, State, Tribal, and Private Sector Child Protection Efforts

RECOMMENDATION F-1: ESTABLISHING A STRUCTURE FOR PLANNING AND COORDINATION AT THE FEDERAL LEVEL

All of the activities which comprise the collective Federal child protection effort should have the same goal: the reduction in the prevalence of child abuse and neglect, primarily through assistance to State, Tribal, and local authorities in their efforts to protect children from abuse and neglect, especially their efforts to build services for child protection at the community level.

The Federal Government should establish an agency or entity to plan and coordinate the accomplishment of that goal. The agency or entity should be mandated to develop--in concert with the agencies throughout the Federal Government whose programs constitute the collective Federal effort--both a long-range strategy for accomplishment of the goal as well as short-term approaches leading toward that end, and to set forth that strategy and those approaches in the form of a readily achievable, comprehensive plan.

In addition to developing the plan, the agency or entity should:

- *assist the President, the Secretary of Health and Human Services, and the heads of other relevant agencies in enlisting opinion leaders in efforts:*
    - *to reduce societal influences (such as the acceptability of violence in the media, the schools, and other social institutions) that may increase the probability of family violence, child abuse and neglect, and violent crime;*
    - *to increase social and material support for families that will decrease child abuse and neglect and other forms of family dysfunction; and*
    - *to increase social support for children that will ameliorate the effects of abuse and neglect when maltreatment does occur;*
- *identify problems related to child abuse and neglect that are receiving inadequate national attention;*
- *convene meetings of leaders in business, labor, religious, civic and philanthropic organizations, the media, professional associations, scientific societies, and volunteer and parent organizations to facilitate their active and constructive response to such problems;*
- *support educational campaigns designed to increase the sophistication of citizens--especially the over two million employed by the Federal Government--of the nature and complexity of child abuse and neglect and to inform them about alternative steps (beyond reporting suspected maltreatment) that they may take to increase the safety of children;*
- *develop public/private partnerships aimed at enhancing the role of the private sector in the prevention and treatment of child abuse and neglect;*
- *coordinate the provision of technical assistance to Federal, State, and Tribal agencies;*
- *coordinate the multi-agency review of the single comprehensive State and Tribal plans described in Recommendation F-2;*
- *monitor policy and program implementation at all levels of government; and, as necessary;*
- *convene key actors from throughout the Federal Government for collaborative policy formulation, program design, and investment in joint funding ventures.*

The agency or entity should be located at an appropriate organizational level. It should be vested with authority commensurate with the nature of its responsibilities. It should be given adequate resources.

Congressional Options for Action

47. Use the next CAPTA reauthorization to mandate the designation of NCCAN or the Inter-Agency Task Force on Child Abuse and Neglect as the planning and coordination agency or entity, locating it at an appropriate organizational level, vesting it with authority commensurate with the nature of its responsibilities, and giving it adequate resources.

48. Alternatively, use the next CAPTA reauthorization to establish a new agency or entity at a high level of the Executive Branch. If this option is selected, the agency or entity should be headed by a Director appointed by the President with the advice and consent of the Senate. The agency or entity should be located at an appropriate organizational level, should be vested with authority commensurate with the nature of its responsibilities, and should be given adequate resources.

49. Whichever option is chosen, use the next CAPTA reauthorization to mandate the strengthening of the Inter-Agency Task Force on Child Abuse and Neglect by:

-- reconstituting it as an Inter-Agency Policy Council consisting of Cabinet officers and other relevant agency heads with responsibility for implementation of Federal child protection policy and development of related policies of the Administration;

-- making the Secretary of Health and Human Services the chair of the Council with his/her authority to delegate that responsibility limited to the head of the planning and coordination agency or entity;

-- including as members of the Council the Secretaries of Agriculture, Defense, Education, Health and Human Services, Housing and Urban Development, and Interior, the Attorney General, and the Directors of ACTION and the Office of National Drug Control Policy, with their authority to delegate their responsibilities within the Council limited to no more than one layer;

-- requiring that the Council meet at least three times per year;

-- encouraging the Council to set up--for purposes of planning and implementation--both permanent and ad hoc work groups and task forces consisting of technical experts drawn from member agencies;

-- providing staff and other resources for the operation of the Council; and

-- integrating and coordinating the work of the Council with the work of the Federal Council on Children, Youth, and Families authorized by the Pepper Young Americans Act.

RECOMMENDATION F-2: ESTABLISHING A STRUCTURE FOR PLANNING AND COORDINATION AT THE STATE AND TRIBAL LEVEL

The Federal Government should require any State or Tribe receiving any formula grant for child protection (including--but not limited to--any grants legislated in response to this report, grants pursuant to CAPTA, the existing Social Services Block Grant, and Titles IV-B and IV-E of the Social Security Act) to submit a comprehensive three-year plan for multidisciplinary investigation, prevention, and treatment of child abuse and neglect. This single comprehensive plan should be a major eligibility requirement for these Federal formula grants, providing States and Tribes with the opportunity to make a single application to the agency or entity described in Recommendation F-1 for funds from several agencies. That agency or entity should be authorized to exercise discretion in waiving discretionary grant requirements that may impede the blending of Federal funds. As an alternative to full-scale implementation of the comprehensive State or Tribal planning requirement, the Federal Government should initiate a multi-year series of pilot projects aimed at testing the core concepts underlying the requirement.

Congressional Options for Actions

50. Use the next CAPTA reauthorization to legislate the State and Tribal planning requirement and, following legislation, appropriate the necessary funds for initial planning grants.

51. Use the next CAPTA reauthorization to authorize the pilot projects.

RECOMMENDATION F-3: PROVIDING FOR COMPREHENSIVE FEDERAL PLANNING AND COORDINATION IN RESPONSE TO CHILD MALTREATMENT FATALITIES

The Federal Government should ensure that issues related to child deaths resulting from abuse or neglect are properly addressed by all relevant Federal agencies, acting collaboratively. The Federal entities involved in such collaboration should include, but not be limited to: such DHHS entities as NCCAN, the Children's Bureau, the Centers for Disease Control, the Health Resources and Services Administration, the Office for Substance Abuse Prevention, and the National Institute of Mental Health; such Department of Justice entities as the Criminal Division, the Office of Juvenile Justice and Delinquency Prevention, the National Institute of Justice, and the Federal Bureau of Investigation; and the Department of Education. Also involved should be Federal entities that have direct service provision responsibilities for families and children, such as the Department of Defense, the Indian Health Service of DHHS, the Bureau of Indian Affairs of the Department of the Interior, and the Office of Victims of Crime of the Department of Justice.

Such collaborative efforts should address such issues as:

- *the review of Federal statutes and regulations that may create barriers to inter-agency, multidisciplinary collaboration at the Federal, State, Tribal, and community level in the investigation, intervention, and review of suspected child fatalities;*
- *the development of model protocols and procedures for both individual State, Tribal, and local agencies, as well as for inter-agency, multidisciplinary collaboration in the investigation, intervention, and service provision in cases of child fatalities;*
- *the development of uniform national data gathering and analysis related to child fatalities; and*
- *the on-going funding of research and training relating to the responses of the Federal, State, Tribal, and local governments to the problem of child fatalities, including how such responses contribute, if at all, to the prevention of child maltreatment in general as well as child maltreatment fatalities.*

Congressional Options for Action

52. Appropriate the necessary funds for the work of the National Commission on Child and Youth Deaths.
53. Use the next CAPTA reauthorization to establish within relevant agencies throughout the Federal Government a funding priority for research, demonstration projects, technical assistance, and training on child maltreatment fatalities. Specific elements to facilitate the coordination and expansion of State, Tribal, and local death review teams should be included in this funding priority.

Implementing a Dramatic New Federal Initiative Aimed at Preventing Child Maltreatment-- Piloting Universal Voluntary Neonatal Home Visitation

RECOMMENDATION G-1: PILOTING UNIVERSAL VOLUNTARY NEONATAL HOME VISITATION

The Federal Government should begin planning for the sequential implementation of a universal voluntary neonatal home visitation system. The first step in the planning process should be the funding of a large series of coordinated pilot projects. Instead of reaffirming the efficacy of home visiting as a preventive measure--already well-established--these projects should aim at providing the Federal Government with the information needed to establish and administer a national home visitation system.

Congressional Options for Action

54. Use the next CAPTA reauthorization to authorize the sequential implementation of a universal voluntary system of neonatal home visitation services as well as to require DHHS to launch the pilot projects, to develop Caring Community Programs, to approach insurers aggressively, especially the insurers of Federal employees, to provide home visitation through the Indian Health Service, and to work with the Department of Defense on the provision of home visitation to military families.

Chairman OWENS. Thank you.

Mr. Tom Birch.

Mr. BIRCH. Good morning. Thank you Mr. Chairman.

Members of the subcommittee, I'm Tom Birch. I am the legislative counsel for the National Child Abuse Coalition, which represents the combined advocacy effort of some 30 national organizations aimed at focusing Federal attention on child abuse.

I'd like to begin by expressing the appreciation of all the organizations in the coalition for the efforts of yourself, Mr. Chairman, Mr. Ballenger, Mr. Klug, and your colleagues on the subcommittee, on behalf of abused and neglected children.

We are especially grateful for your obvious concern for strengthening the Federal role in the topic that we are talking about here today.

At our coalition's November 1991 meeting we, as a body of organizations, agreed that the purpose of NCCAN is to create an opportunity for the Federal Government to exert leadership in strengthening the broad child protection system.

Because there is no language in the Federal statute to guide the action of NCCAN—Howard Davidson just referred to that issue—we would agree and believe that the reauthorization of CAPTA should include a broad mission statement for NCCAN that establishes it as a national leader in the prevention, identification, and treatment of child abuse and neglect.

The coalition also agreed that other Federal agencies have a role to play in protecting children and should share in that endeavor.

When I testified before this subcommittee almost a year ago on the subject of NCCAN and the reauthorization of the Child Abuse Prevention and Treatment Act, we identified a number of outstanding issues which demanded correction.

At this time, I can report to the subcommittee that progress has been made in solving some of those issues—and you've heard instances of that from some of the witnesses who have preceded me—and that we have also had progress in developing answers, legislative responses, if you will, to some of the problems that are still outstanding.

A year ago, I spoke of the lack of attention within the administration to offer leadership in activities related to child abuse and neglect.

Obviously, there is much more that can be done within the Department of Health and Human Services to improve the capacity of NCCAN, but we are very encouraged by the example set by Secretary Louis Sullivan in developing an initiative on child abuse which has raised attention to the problem to new levels of visibility within the Department.

We were, a year ago, dissatisfied with the longstanding failure of HHS to appoint a full-time director of NCCAN with experience in the field of child abuse, and with the absence of adequate staff with the requisite expertise.

Now, for the first time in over 10 years, NCCAN is led by a director whose knowledge and background in child abuse are a credit to the agency, and NCCAN's professional staff, again, as you've already been told, has increased to bring on individuals with the experience the agency should have.

Other issues do remain unresolved. Howard Davidson has mentioned some of them, and I'd like to address a few of those. In so doing, I would propose on behalf of the Child Abuse Coalition legislative action on these issues for your consideration in reauthorizing CAPTA.

First, let me address research. Over the years, NCCAN's support of research has been hampered by limited funding, an inferior peer review system, and inadequate staff expertise and support. The result is that NCCAN has not attracted many of the top researchers in the country and has not encouraged sophisticated research methods.

What the field needs is a detailed, scientifically grounded understanding of the antecedents and consequences of child abuse and neglect. But, as I said, little attention has been paid to establishing a research agenda from year to year that builds on knowledge already gained.

In the context of CAPTA reauthorization, the coalition believes that NCCAN is an appropriate agency to carry out research, given certain changes in CAPTA to improve NCCAN's capacity to conduct a grant support program in research.

CAPTA should be amended to require standing review panels—again, I'm echoing the advisory board's recommendation—for research and also for demonstration grant application, such as now exist at NIMH, NIH, and the National Science Foundation, to professionalize within NCCAN the whole research function and mirror those excellent examples of research activities in other organizations.

Standing review panels of competent scientists would help to professionalize the program at NCCAN. With the names of reviewers known to the community, the credibility of the process would be bolstered and be open to public scrutiny.

NCCAN's review process should be more interactive so that information on shaping and developing research proposals could improve the approach of the overall Federal child abuse research agenda.

Second: evaluations. We have expressed before frustration with the lack of evaluative information on the results of NCCAN-funded projects. NCCAN has typically not undertaken outcome evaluations of demonstration projects funded under the discretionary grant program.

As a result, very little is understood about the value of activities that NCCAN has supported, hampering the development of programs and the replication of worthwhile efforts.

The coalition believes that CAPTA should require evaluations of all NCCAN-funded demonstration projects. CAPTA should mandate NCCAN to provide for evaluations of all demonstrations funded, either as a percentage of a particular grant or as a separate grant for evaluation of a cluster of programs, built in at the beginning to the scope of the funded project.

Some demonstration grants awarded by NCCAN are so small that to earmark a percentage for an evaluation would either not provide enough for an effective evaluation, or would take away the funding needed for the activity.

What we are suggesting is in those cases—and it's typical NCCAN funds a group of programs that runs off its demonstration activities on a particular topic—is that an evaluation be funded to work with all of those.

Third, from the beginning, NCCAN supported a data collection effort that became the baseline against which we measured our knowledge about the problem. Six years ago, as you know, that effort was suspended by NCCAN and only now has the collection of data been revived. This is an important Federal responsibility which needs to be undertaken in a way that produces accurate, available data.

We recommend that CAPTA be amended to establish as a mandatory function of NCCAN the collection of universal, case-specific child abuse and neglect reporting information from the States. The collection of child abuse and neglect reporting information should be integrated with case-based foster care and adoption data which is mandated through legislation coming out of the House Ways and Means Committee.

Let me talk a bit about State grants, and some ideas for improving the measure of Federal support to States in strengthening child abuse and neglect prevention and treatment activities.

Through its program of State grants established in 1984, NCCAN has helped the States improve their own child abuse laws and programs to prevent and treat child abuse.

Federal grants supplement State funds with seed money to support training, public education, and special efforts in treatment and prevention activities. The small size of these grants, however, makes it difficult for States to engage in any significant reform efforts.

I would suggest, too, that the sort of broad scope of the purpose of the grants makes it difficult for any real movement to go forward in child protective service systems, nationally.

What is more, our primary service response to cases of abuse and neglect has been to place children in out-of-home care, echoing some of the testimony from Mr. Goodling at the outset of this hearing.

As a result, we have a situation where Congress currently appropriates over $207 million to Title IV(b) chid welfare services, to meet the needs of children removed from their homes because of abuse and neglect.

By contrast, less than $20 million is available through CAPTA in grants to States to attempt to improve the child protective service system that first receives the reports of maltreatment, conducts the investigations, and manages the caseloads of families in trouble.

In other hearings before this subcommittee, you have heard that child protective services have been hard pressed in recent years to provide adequate care for maltreated children and families in distress.

While cases of child abuse and neglect have increased in number to 2.5 million reported a year ago, and complexity with problems of substance abuse, homelessness, and unemployment cited as principal contributing factors, the ability of child welfare agencies to protect children has not substantially improved in recent years.

Over half the States a year ago received no real increase in State funding to help meet the load of reported cases. Federal support has been inadequate as well—what the U.S. Advisory Board has called "insufficient", leading to "enormous disparity between Federal appropriations and the rise in the child protection system caseload."

We urge your adoption of a new program of Federal grant support to States, in place of, not in addition to—not an additional program, but as a replacement for—the current CAPTA State grant authority, to focus on improving the overburdened child protective service systems. Senate Legislation S.838 includes such a provision which we, as a coalition, support.

What we propose is a change in the nature of the CAPTA State grant program from one of support for a broad range of activities to one which concentrates support at an authorized funding level of $100 million on helping States improve their child protective services; funding which should help to respond in part to the national emergency in child protection which the U.S. Advisory Board identified in its 1990 report.

While other Federal programs assist States in dealing with cases of maltreated children requiring intensive intervention, including foster care, the Title IV programs that I mentioned just a minute ago, no other Federal program specifically aims support at the primary operations of the child protective service agency.

We believe this is a serious gap in Federal assistance to the child welfare system which should be addressed in CAPTA.

In redirecting the CAPTA State grant program, we propose authorizing grants to assist States in improving their child protective service systems in:

1. the intake and screening of reports of abuse and neglect through the improvement of the receipt of information, decision-making, public awareness, and training of staff;
2. investigating reports through improved decision-making and training of staff, use of multi-disciplinary teams and interagency protocols for investigations, and legal representation;
3. case management and delivery of services to families through improved response time and training of staff; and
4. general system improvements in assessment tools, automated systems, information referral, and again, staff training to meet minimum competencies.

I would suggest that these kinds of improvements which I've just outlined for you address the issues identified by Representative Goodling in the statement that he read to go toward developing a professional accounting system.

I might mention, because Dr. Horn said something about stepping up training for workers in this system, I believe the training that Dr. Horn mentioned is only limited to the Title V(e) foster care case management activities, not for case workers in child protective service systems who are dealing with reports and investigations and case management. Again, this is an area in which we do lack a Federal response.

A second category of State grants are the prevention grants. Essential to the component of NCCAN's grant support to States is the development of prevention and early intervention services to help families before abuse and neglect occur.

In 1984, Congress enacted the prevention challenge grants to encourage States providing funds for the support of child abuse prevention projects. Current funding is slightly more than $5 million.

Since the implementation of the challenge grant program, Federal appropriations have never been adequate to fully meet the match authorized by the statute.

With current funding levels, both State and Federal dollars combined, States are able to fund only a portion of those community-based prevention efforts seeking State assistance—as few as 8 percent of eligible applicants in some States.

The need continues for Federal grants to support and encourage States to allocate funds for prevention. According to a 1991 GAO report, a few States expect legislative changes that could result in even lower revenues for these prevention activities. A continuing recession or worsening fiscal crisis in the States could threaten prevention spending in other States as well.

With the increase we propose in authorized funding to $50 million annually, the Federal Government can help States do a better job of getting the necessary resources to the local level where they are needed. By offering services to all parents, as well as targeted, at-risk populations, we can prevent much more costly forms of abuse.

Each case of child abuse costs anywhere from $2,000 to $5,000 for an investigation and a short-term treatment; this becomes significantly greater when a child has to be hospitalized or put into foster care.

Other costs can arise later. Overwhelming numbers of juvenile offenders, adolescent runaways, violent criminals, sexual offenders, and prostitutes report childhood histories of battering and exploitation. Prevention is the most effective weapon we have of combatting child abuse and its consequences.

In conclusion, the Child Abuse Prevention and Treatment Act has, in fact, been an effective force in creating, since the 1970's, an infrastructure in the States for responding to reports of abuse. Unfortunately, the Federal response today bears almost no relationship to the extent of the problem of child maltreatment in our country.

While the numbers of abused and neglected children between 1975 and 1990 have grown by 273 percent, the total appropriated budget for NCCAN, when adjusted for inflation, has gone down by 35 percent. The prevention of child abuse requires an intensive effort and the commitment of resources such as we have rarely seen in government; certainly more than has been allocated to date through the CAPTA.

We are at a point now where we can act to improve the Federal support and leadership from NCCAN. We urge your expeditious adoption of legislation to amend CAPTA in ways that will strengthen NCCAN's activities and intensify the shape and scope of Federal assistance to States.

Speaking for myself and the members of the Child Abuse Coalition, we stand ready to assist the subcommittee and your colleagues in Congress in developing a new Federal role in protecting children and preventing child abuse.

Thank you.

[The prepared statement of Tom Birch follows:]

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TESTIMONY OF

THOMAS BIRCH

LEGISLATIVE COUNSEL

NATIONAL CHILD ABUSE COALITION

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

THURSDAY, FEBRUARY 27, 1992

TESTIMONY OF THOMAS BIRCH
LEGISLATIVE COUNSEL, NATIONAL CHILD ABUSE COALITION
BEFORE THE SUBCOMMITTEE ON SELECT EDUCATION
COMMITTEE ON EDUCATION AND LABOR, U.S. HOUSE OF REPRESENTATIVES
THURSDAY, FEBRUARY 27, 1992

Mr. Chairman and members of the subcommittee, my name is Thomas Birch and I am the legislative counsel for the National Child Abuse Coalition, which represents the combined advocacy effort of more than thirty national organizations aimed at focusing federal attention on child abuse.

I would like to begin by expressing the appreciation of all the organizations in the coalition for your efforts, Mr. Chairman, and those of the members of the subcommittee on behalf of abused and neglected children. We are grateful for your obvious concern for strengthening the federal role in addressing the protection of children and the prevention child abuse and neglect.

Role of NCCAN

At our coalition's November 1991 meeting, we agreed that the purpose of the National Center on Child Abuse and Neglect (NCCAN) is to create an opportunity for the federal government to exert leadership in strengthening the broad child protection system. Because there is no language in the federal statute to guide the action of NCCAN, we believe that the reauthorization of CAPTA should include a broad mission statement for NCCAN that establishes it as a national leader in the prevention, identification, and treatment of child abuse and neglect. The Coalition also agreed that other federal agencies have a role to play in protecting children and should share in that endeavor.

When I testified before this subcommittee almost a year ago on the subject of NCCAN) and the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), there were a number of outstanding issues which demanded correction. At this time, I can report to the subcommittee that progress has been made in solving some of those issues and in developing answers to some of the problems still outstanding.

A year ago, I spoke of the lack of attention within the administration to offer leadership in activities related to child abuse and neglect. While much more can be done within the Department of Health and Human Services to improve the capacity of NCCAN, we are encouraged by the example set by Secretary Louis Sullivan in developing an initiative on child abuse which has raised attention to the problem to new levels of visibility within the department.

We were dissatisfied with the longstanding failure of HHS to appoint a full-time director of NCCAN with experience in the field of child abuse, and the absence of adequate staff with the requisite expertise was a concern of ours. Now for the first time in over ten years, NCCAN is led by a director whose knowledge and background in child abuse are a credit to the agency, and NCCAN's professional staff has almost doubled to bring on individuals with the experience the agency deserves.

Other issues remain unresolved. Today, I would propose on behalf of the National Child Abuse Coalition legislative action on these matters for your consideration in reauthorizing CAPTA.

First, let me address research. Over the years, NCCAN's support of research has been hampered by limited funding, an inferior peer review system, and inadequate staff expertise and support. The result is that NCCAN has not attracted many of the top researchers and has not encouraged sophisticated research methods. The field needs a detailed, scientifically grounded understanding of the antecedents and consequences of child abuse and neglect, but little attention has been paid to establishing a sequential research agenda from year to year that builds on knowledge already gained.

In the context of CAPTA reauthorization, the Coalition believes that NCCAN is an appropriate agency to carry out research, given certain changes in CAPTA to improve NCCAN's capacity to conduct a grant support program in research.

CAPTA should be amended to require standing review panels for NCCAN research (and demonstration) grant applications, such as exist at NIMH, NIH, and NSF. Standing review panels of competent scientists would help to professionalize the currently discredited process and program at NCCAN. With the names of reviewers known to the community, the credibility of the process would be bolstered and be open to public scrutiny. NCCAN's review process should be more interactive (now poorly rated relative to other federal agencies), so that information on shaping and developing research proposals could improve the approach of the overall federal child abuse research agenda.

Second, we have before expressed frustration with the lack of evaluative information about the results of NCCAN-funded projects. NCCAN has typically not undertaken outcome evaluations of demonstration projects funded under the discretionary grant program. As a result, very little is understood about the value of activities NCCAN has supported, hampering the development of programs and the replication of worthwhile efforts.

The Coalition believes that CAPTA should require evaluations of all NCCAN-funded demonstration projects. Because the size of NCCAN's demonstration grants varies substantially, it is not practical simply to require that all demonstration grantees earmark a percentage of the grant amount for evaluation. Rather, CAPTA should mandate NCCAN to provide for evaluations of all demonstrations, funded either as a percentage of a particular grant, or as a separate grant for evaluation of a cluster of programs built in at the beginning to the scope of the funding proposed by NCCAN. Typically, NCCAN would fund a group of demonstrations (as it often does now) and fund an evaluator to work with the demonstrations integral to and from the start of the funded project.

Third, from the beginning NCCAN supported a data collection effort that became the baseline against which we measured our knowledge about the extent of the problem and the characteristics of children who are abused and neglected. Six years ago that effort was suspended by NCCAN and only now is the collection of data being revived. This is another important federal responsibility which needs to be undertaken in a way that produces accurate, available data that is coordinated with other information collected about children.

We recommend that CAPTA be amended to establish as a mandatory function of NCCAN the collection of universal, case specific child abuse and neglect reporting information from the states. The collection of child abuse and neglect reporting information should be integrated with case-based foster care and adoption data.

Such an effort should involve technical assistance to the states in order to achieve relatively uniform data on a national basis and to achieve the successful integration of all child welfare information.

Fourth, I would point out that much attention has focused on the need to use children and youth serving voluntary agencies, that are community and neighborhood based, as a vehicle for child abuse and neglect prevention programs, as well as the need to prevent child maltreatment by the staff and volunteers from the agencies. These voluntary agencies reach and help tens of millions of children and youth daily. Recruitment, selection, and training of volunteers stands improving as a means of preventing abuse of children.

We propose amending CAPTA to provide authority for discretionary grant funds to support the development of model programs in the recruitment, selection, and training of volunteers for the prevention of child abuse and neglect in children, youth, and family serving organizations.

CAPTA State Grants

I would like to turn now to our most important concern -- improving the measure of federal support to states in strengthening child abuse and neglect prevention and treatment activities.

Through its program of state grants established in 1974, NCCAN has helped the states improve their own child abuse laws and programs to prevent and treat child abuse. Federal grants supplement state funds with seed money to support training, public education, and special efforts in treatment and prevention of child abuse. The small size of these grants, however, make it difficult for states to engage in any significant reform efforts.

What is more, our primary service response to cases of abuse and neglect have been to place children in out-of-home care. As a result, Congress currently appropriates over $270 million to Title IV-B child welfare services to meet the needs of children removed from their homes because of abuse and neglect as well as those who could safely remain with their families. By contract, less than $20 million is available through CAPTA in grants to states to improve the child protective service systems that first receive reports of maltreatment, conduct the investigations, and manage the caseloads of families in trouble.

In other hearings before this subcommittee, you have heard that child protective services have been hard pressed in recent years to provide adequate care for maltreated children and families in distress. In 1990, an estimated 2,508,000 children were reported as victims of child abuse or neglect, representing a 31 percent increase in reports between 1985 and 1990.

While cases of child abuse and neglect have increased in number and complexity, with problems of substance abuse, homelessness and unemployment cited as principal contributing factors to the elevated levels of maltreatment, the ability of child welfare agencies to protect children has not substantially improved in recent years. Over half the states in 1990 received no real increase in state funding to help meet the load of reported cases. Federal support has been inadequate as well. The U.S. Advisory Board on Child Abuse and Neglect reported in 1990 that federal funds for child abuse and neglect have been "insufficient", leading to an "enormous...disparity between federal appropriations and the rise in the child protection system caseload."

We urge your adoption of a new program of federal grant support to states, in place of the current CAPTA state grant authority, which focuses on improving overburdened child protective service systems. The Senate legislation reauthorizing CAPTA, S. 838, includes such a provision which we support. What we propose is a change in the nature of the CAPTA state grant program from one of support for a broad range of discretionary activities to one which concentrates support, at an authorized funding level of $100 million, on helping states improve their child protective services, funding which should help to respond in part to the national emergency in child protection which the U.S. Advisory Board on Child Abuse and Neglect identified in its 1990 report.

While other federal programs assist states in dealing with cases of maltreated children requiring intensive intervention, including foster care, no other federal program specifically aims support at the primary operations of the child protective service agency. We believe this is a serious gap in federal assistance to the child welfare system which should be addressed in CAPTA.

In redir cting the CAPTA state grant program, the legislation authorizes grants to assist states in improving their child protective service systems in: (1) the intake and screening of reports of abuse and neglect through the improvement of the receipt of information, decisionmaking, public awareness, and training of staff; (2) investigating reports through improved decisionmaking and training of staff, use of multidisciplinary teams and interagency protocols for investigations, and legal representation; (3) case management and delivery of services to families through improved response time and training of staff; and (4) general system improvements in assessment tools, automated systems, information referral, and staff training to meet minimum competencies.

States would also be allowed to spend up to 15 percent of their grant allocations on current authorized CAPTA state grant activities in developing, strengthening, and carrying out child abuse and neglect prevention, treatment, and research programs. Because we do not want to disrupt state plans and programs in child abuse and neglect in directing the focus of the CAPTA state grant program to assistance for CPS systems improvement, states should be able to continue to spend up to 100 percent of their grants on the kinds of general activities currently authorized until appropriations for this section exceed $40 million.

Prevention Grants

The second essential component of NCCAN's grant support to states recognizes that the reform of CPS must be accompanied by the development of prevention and early intervention services to help families before abuse and neglect occur.

In 1984, Congress enacted the prevention challenge grants to encourage states providing funds for the support of child abuse prevention projects. The current federal appropriation of slightly more than $5 million funds this effort. Since the implementation of the challenge grant programs, federal appropriations have never been adequate to fully meet the match authorized by the statute. With current funding levels, both state and federal dollars combined, states are able to fund only a portion of community-based prevention efforts seeking state assistance -- as few as 8 percent of eligible applicants in some states.

The need continues for federal grant support to encourage states to allocate funds for the prevention of child maltreatment. According to a May 1991 report from the U.S. General Accounting Office (Child Abuse Prevention: Status of the Challenge Grant Program) a few states expect legislative changes that could result in lower trust fund revenues. For example, changes in the state income tax form in Oregon and Indiana will likely reduce trust fund revenues. In Connecticut, the appropriation to the trust fund was cut so that the trust fund must now rely on private funding and challenge grants to fund prevention. Massachusetts reduced its fiscal goal because of state economic problems. A continuing recession or worsening fiscal crises in the states could threaten prevention spending in other states as well.

With the increase we propose in authorized funding to $50 million annually, the federal government can help states do a better job of getting the necessary resources to the local level where they are needed. By offering services to all parents, as well as targeted, at-risk populations, we can prevent much more costly forms of intervention. Each case of child abuse costs anywhere from $2,000 to $5,000 for an investigation and short-term treatment, significantly more when a child must be hospitalized or put in foster care. Other costs can arise later. Overwhelming numbers of juvenile offenders, adolescent runaways, violent criminals, sexual offenders, and prostitutes report childhood histories of battering and exploitation. Prevention is the most effective weapon we have of combatting child abuse and its consequences.

Conclusion

The Child Abuse Prevention and Treatment Act has in fact been a powerful force in creating since the 1970's an infrastructure in the states for responding to reports of child abuse and neglect. Unfortunately, the federal response bears almost no relationship to the extent of the problem of child maltreatment in our society. While the numbers of abused and neglected children between 1975 and 1990 have grown by 273 percent, the total appropriated budget for NCCAN, when adjusted for inflation, has gone down by 35 percent. The prevention of child abuse requires intensive effort and the commitment of resources such as we rarely see in government, certainly more than has been allocated to date through the Child Abuse Prevention and Treatment Act.

We are at a point now where we can act to improve upon the federal support and leadership from NCCAN. We urge your expeditious adoption of legislation to amend CAPTA in ways that will strengthen NCCAN's activities and intensify the shape and scope of federal assistance to the states.

Speaking for myself and for the members of the National Child Abuse Coalition, we stand ready to assist the subcommittee and your colleagues in Congress in developing a new federal role in protecting children and preventing child abuse.

Chairman **Owens**. I want to thank each one of you.

At the heart of your comments is the basic question of how much priority the Federal Government has assigned to this activity. Related to that is the question of whether this effort that we have going is a sham; a fraud.

Would you care to comment, Mr. Delfico, on how your agency reaches the conclusion that we need a minimum of 10 more staff persons? Is HHS treating in-kind in a manner different from the way they arrive at decisions on staffing of their other units?

Can't they see what you see in terms of the workload and the minimum requirements for staff for such an agency, or do they see it and dismiss it?

Mr. **Delfico**. I think there are two things going on at the same time, Mr. Chairman.

We see a need for increased staff to handle the increased workload if you are going to keep NCCAN effective. The problem, though, is pretty government-wide as far as resources for social service programs and human service programs.

I've testified on many occasions on what some have referred to as the "hollow government syndrome" that people are recognizing now throughout the government, and what you see here——

Chairman **Owens**. What syndrome?

Mr. **Delfico**. Hollow government.

Chairman **Owens**. Hollow?

Mr. **Delfico**. Government syndrome. It's a catch word that I've been seeing in the press nowadays.

But it becomes more and more apparent to me as I get into NCCAN, HHS and the human service programs that the workloads are skyrocketing, and staffing levels are remaining constant. In this case, they are decreasing.

I'd like to clear up the fact that although there are 26 people—or 26 potential people—at NCCAN, there are 20 authorized positions, and that's lower than last year. The 26 includes detailees and temporary people. They are not permanent FTE's, so I think you need to put that into perspective.

As far as HHS treating NCCAN differently, I don't know what has gone on in their budget allocation process throughout the years. I do know though that NCCAN has not received the attention, until just recently, that other agencies have.

I think with NCCAN now being out of the Children's Bureau, having more visibility within HHS, this is a positive sign. I see this as a positive signal and I think it is going to take time to work out, but this is something that I think this committee or the subcommittee should take some credit for.

I think the pressure you've kept on them over the years has got them to do that. I'm not very sanguine in the long run in how NCCAN is going to function with its increasing workload.

Our problem is that we think of the work that they can do, and if given proper resources, they would achieve the CAPTA mandates to be leaders in the area of child abuse and neglect and prevention; but, we don't see this happening in the short run because of the budget difficulties and because of the difficulties we see in allocation of resources within HHS.

That's my long answer to a short question of yours.

Chairman OWENS. Given our meager resources, it seems to me every entity involved in this endeavor should seek to maximize cooperation with the other.

Mr. Davidson, some of your remarks imply that NCCAN and the administration have not exactly welcomed your presence. Did they deliberately distort matters when they said that you received a $1,000 per day versus $289, and the $200,000 contracting money for the board, that you said you don't know anything about? What is the——

Mr. DAVIDSON. I don't want to attribute anything to Commissioner Horn. We have had a very straightforward, up-front relationship with him, and I respect him and what he is trying to do to strengthen not only NCCAN but the Children's Bureau.

So, I mean, I'm sure we can, after this hearing, get some clarification as to——

Chairman OWENS. OMB often writes the speeches, so maybe OMB was off.

Mr. DAVIDSON. I don't know, but I did want to clear that up.

I also want to say that although the Board has been critical about the lack of inter-agency cooperation, there have been some strides in 1988. The legislation that you were responsible for, in amending CAPTA, created an Inter-Agency Task Force that is beginning to have some impact on the actions of a variety of Federal agencies.

In the view of the Board, it is not enough, but it is a beginning. There are some very good people who work on child abuse issues in various Federal agencies and the task force has been given staff. It's meeting periodically. It's forming into work groups, and it's doing something that I think will move us ahead.

But as I stated in my testimony, unless we institutionalize inter-agency cooperation, and unless we institutionalize activities on child protection in the Department of Education and the Department of Justice, and elsewhere, these improvements and enhancements may be here today and gone tomorrow.

Chairman OWENS. Thank you.

Mr. Birch, you heard me say earlier that I used a sentence which was exactly the same that I used in the previous reauthorization hearings several years ago.

Much of your testimony also rings that way in my ear. A lot of things that you are saying now, you said in the last hearing when we considered the reauthorization of the bill, and things have not changed, unfortunately.

Do you think there is any creative way we can have an interplay between the $270 million being spent for protective services versus the $20 million that is available for prevention?

Or would that be fruitless because $270 million is so inadequate? Is there any way we can cooperate better; merge the two functions to get a better return on our money?

Mr. BIRCH. I'm not sure how the functions can be merged—the $270 that we are talking about is spent on foster care.

The approach that I would present here is to change the focus of the attention. The budget, I think, drives policy. The focus, as I mentioned in my testimony, has been on removing children from home and putting them in foster care, and there is Federal money to pay for that. So, that kind of activity is one that in some ways is an easy solution.

What we haven't got is attention on spending money to help families before a child is removed from the home; to improve the investigations of cases when a case worker goes into a home to investigate a report of child abuse. There's support for that worker in terms of the training and background that individual brings to the investigation and the ability to get services for that family, which are much less costly than waiting around for the situation to get worse—for the child to be abused again and then taken out of the home and put in foster care, which costs a lot more in the long run.

So my response, Mr. Chairman, is that by beginning to put our resources at the front end of the problem, we should see that $270 shrink down the road, because we won't find the necessity to put children in foster care.

The foster care budget should go down because we are taking care of families at the front end and giving them support they need before the problems happen.

Chairman OWENS. Mr. Davidson, States have incentives, and local governments have incentives; is there any creative way we can link the two?

Mr. DAVIDSON. If I can get back to something I said in my testimony, I think it is awkward that Ways and Means has jurisdiction over the program that Tom has been talking about.

Mr. Downey, as you know, has legislation pending in the Congress this year to make reforms in the Adoption Assistance and Child Welfare Act that has been focused on foster care, not on strengthening and supporting families up front to make those kinds of changes.

You are working here on one subcommittee, while Ways and Means is working on another aspect of this, with a lot more money. I've never understood why there is the split other than historically, the jurisdiction has been split.

But I think that if subcommittees could work more closely together—and I know that's certainly been your intention and desire to look at the entire picture, not merely one aspect of it.

As the Board has pointed out in two reports, our approach to this problem has been much too fragmented. We need an overall policy. We need a strategy.

The Board is dedicating itself to helping Congress and the American people understand and to give them a vision of what can be done, not just at the Federal level, but at the community level.

Ultimately, Congress can take action to do what Mr. Birch has suggested in reformulating how it spends its money so that there is more effort in strengthening families than in supporting children in foster care.

But, ultimately, the success of child abuse prevention and treatment efforts are only going to work if community efforts are strengthened, and if we have a truly neighborhood-based, child-centered child protection system.

I think we can get there but, again, the Subcommittee on Select Education can't do it alone.

Mr. **Birch**. Mr. Owens, if I might just add something further.

The legislation, that Howard mentioned that is going through the Downey subcommittee and before Ways and Means, was developed by a very broad coalition in which the child abuse groups were involved, along with child welfare, mental health, and juvenile justice agencies.

We spent 2 years—culminating with a package about a year ago—in looking at the sweep of child welfare, from preventing any maltreatment from ever happening all the way through to foster care and on to adoption.

The piece that is in the Downey bill is meant to fit with the Child Protective Services State grant improvements piece that I've described to you this morning, and the State Challenge Grant prevention piece as well. Those proposals which are in S. 838 were part of a larger package of legislative initiatives, part of which is in the Downey subcommittee. And these are two other pieces that we're presenting before your subcommittee, Mr. Owens, but we see them as being coordinating.

Chairman **Owens**. I certainly think that the efforts of all three of you have helped this process a great deal. Mr. Birch, when you come up with figures like $2,000 to $5,000 as a cost of a child abuse prevention effort, then we've got a hard figure there.

Anyone who watched the film, "Who Killed Adam Mann" would know that the cost of just one session in court exceeded $2,000 to $5,000, let alone the numerous hospital bills that were generated as a result of what was happening to Adam Mann, as well as what was happening to his sisters and brothers.

We are taking some useful individual steps; but, I must confess that each time we review this matter and consider reauthorization, it is overwhelming to see how far behind we are. That's not the fault of the people here, of course.

I want to congratulate all of you for your efforts. The clarity of the Advisory Board is very much appreciated, and the intensity with which you approach your work is also quite welcome. You've shown how a great deal can be accomplished by dedicated, hardworking citizens, and we certainly appreciate that.

Mr. **Davidson**. Thank you, Mr. Chair.

Chairman **Owens**. I was trying to wait for Mr. Ballenger to return, but I think he must have been delayed. I'm sure he'll submit any questions to you in writing.

Thank you very much.

I would like to announce that Ms. Carole Langer, the producer of "Who Killed Adam Mann?" will not appear today because of illness.

We will proceed with the other three members of the panel, Dr. Michael Durfee, Child Abuse Prevention Unit, Department of Health Services, Los Angeles, California; the Honorable Mary Margaret Oliver, State Representative, District 53, Georgia State Legislature, who will be introduced by Congressman Ben Jones; and Dr. Susan Wells, Director, Child Maltreatment Fatalities Project, ABA Center on Children and the Law, Chapel Hill, North Carolina.

Mr. Jones will have a time problem so we will yield him the courtesy of introducing Ms. Oliver when he comes in.

Until then, we will begin with Dr. Michael Durfee of the Child Abuse Prevention Unit in California.

Dr. Durfee.

STATEMENTS OF MICHAEL DURFEE, M.D., CHILD ABUSE PREVENTION UNIT, DEPARTMENT OF HEALTH SERVICES, LOS ANGELES, CALIFORNIA; THE HONORABLE MARY MARGARET OLIVER, STATE REPRESENTATIVE, DISTRICT 53, GEORGIA STATE LEGISLATURE; ACCOMPANIED BY THE HONORABLE BEN JONES, REPRESENTATIVE FROM THE STATE OF GEORGIA; AND SUSAN WELLS, PH.D., DIRECTOR, CHILD MALTREATMENT FATALITIES PROJECT, ABA CENTER ON CHILDREN AND THE LAW, CHAPEL HILL, NORTH CAROLINA

Dr. Durfee. Thank you for the opportunity to testify. I will try to stay in my suggested time limit. Your subcommittee has received materials from me prior to these hearings, and I will be updating you with other materials as they are created.

I'm a child psychiatrist. I coordinate the Child Abuse Prevention Program for the Los Angeles County Department of Health Services in what may well be the largest health-based child abuse prevention program in the world.

I wear a series of hats: with the California Department of Justice; at the Federal level with Health and Human Services and the Department of Justice; and I have been a consultant, both to the American Bar Association and the National Center for Prosecution of Child Abuse for some years, particularly on the issue of child abuse fatalities.

I was also appointed to the President's Commission on Child and Youth Fatalities that was approved and not funded. That is one of the things I wish to speak to.

My expertise at the local, State, and national level has to do with creation of multi-agency child death review teams that use some fairly inclusive mechanisms for intake of cases. That does not equate with reviewing child protective service cases only, as is the case in New York City, although that is probably much more than nothing.

The first such team was created in 1978 in Los Angeles County. By 1988, we had 7 States, and several weeks ago, by my count and by my standards, we had 20 States with multi-agency teams that include representation from the criminal justice, health, and human services, including social services. These teams have some fairly logical ways of looking at what they hope to be the total population of suspicious child deaths.

Primarily using coroner's records, the teams cover approximately 100 million people or 40 percent of the Nation. My guess is that we will tip over half the Nation by the end of this year.

We are also creating regions—multi-state regions. There is a death review team group of six/seven southern States that will be meeting in South Carolina in April of this year.

At the minimum, these teams work with coroner's data; at the maximum, and one of our better models, I believe, is the State of

Colorado that tries to look at all deaths under age 17. That is probably the most common goal for most of us.

There are special studies looking at fetal deaths and at child suicides. We've found that it is not uncommon for children who kill themselves to have previous records in child protective service and juvenile justice.

We are also attempting to look at severe injuries. There is a small group of kids who are brain damaged from a series of injuries, including Shaken Baby Syndrome, that we will put into the multi-agency review form to see how well we can monitor and assist each other in doing a better job for the next child.

Fatal child abuse and neglect cases, in general, have a fairly consistent profile. Almost all of them are under age four. Half of them are under age one, and those really stack up in the first 3 years of life.

Most of the families are poor. They have a history of previous violence, very much including domestic violence. They seem to have a fairly consistent history of substance abuse, very much including alcohol and cocaine.

The babies also seem to have some increased instances of prematurity, lack of prenatal health care, and exposure prenatally to chemicals that damage the pregnancy. Almost all these families, including some of the affluent ones that break some of the previous rules, seem to have suffered from social isolation. They don't have intimate contacts with other people.

But all categories of families are ultimately represented if you look at the incidence of children who die at the hands of a caretaker, which is double definition that we tend to use whenever describing fatal child abuse and neglect.

The outcome of the teams, initially, seems to be an increase in criminal action. In Los Angeles County, our team leader, then-deputy district attorney, now a judge, took seven cases to coroner's inquest that had been signed out as accidental or natural death. These are almost all infants and very young toddlers.

Those seven cases came back from that coroner's inquest with the description, "death at the hands of another," and some years later, there were people in prison, jail, and some families on what is a functional tool; that is, straight probation.

You can monitor, particularly in those families where Mom needs some help to separate herself from a violent boyfriend, and probation officers seem to be more effective than child protective service workers on some issues, that being one of them.

Most of the teams are trying to reach severe abuse so that a child doesn't have to die before becoming a concern for the team. Most teams are trying to reach prevention. We've had campaigns addressing accidental drowning in five gallon buckets. A child about age one can get themselves upside down into a bucket of water and can't get themselves out. We've also had campaigns on fire prevention, putting kids in infant seats, swimming pool drownings, and river drownings.

If I give you a couple of specific cases, one of the most tragic in my experience was the child who had had a series of assaults and finally died at 10 months of age.

A female police officer tracked that case back and found that that child and family had had 52 agency contacts before that death. Basically, every profession is involved in that—law enforcement, child protective service, hospital emergency room, psychiatric, emergency teams, various treatment programs. We did not kill that child, but we were not a whole lot of help in stopping it.

We've had a case where there were multiple children signed out as Sudden Infant Death Syndrome deaths and the mother later confessed to having suffocated both of those.

The problems in the area served by the teams, including Los Angeles County, continue, but at the very least, we are more nearly approaching competence, and in looking backwards, we can feel some sense of accomplishment that we aren't as ignorant as we were a few years ago.

I want to comment on Howard Davidson's reference to the need to integrate multiple agencies and resources. It intrigues me to find that it isn't clear who, in Congress, is responsible for child abuse. I'm going to be expanding my civic lessons in the number of committees that I will be sending paperwork to.

There is a need, besides State and local teams, for a national team or a system to address fatal child abuse. Someone needs to help us find each other, and someone needs to help clarify some questions, including confidentiality.

As I read the Child Abuse and Prevention Treatment Act, there is a specific direction that States should honor confidentiality for the necessary protection of children and families.

There is no comment that States should honor the need for interagency communication; that we'd literally take on honoring confidentiality. Then if I'm a public health physician and I know a 3-year-old has gonorrhea, and I suspect the parent who owns the confidentiality, I should not release that information. We have at least one State that is struggling with whether or not they can have a team, in part because of that specific dilemma.

At the national level, we not only need teams to share resources, training, protocols, but maybe have some company while we feel the personal pain that seems to go with the death of a child. Being a professional does not end that pain.

But Federal agencies that directly serve families, specifically the Department of Defense and Indian Health Services, need to address what activities they have for child abuse in general, and child abuse fatalities in specific.

Much of this has begun in the last few months. Secretary Sullivan has been responsive to some recommendations of the U.S. Advisory Board. There is a task force now shared by Social Worker and Maternal Child Health that includes multiple points within Health and Human Services, the Department of Defense, Indian Health Services, and a new member from the Department of Justice.

But we also need resources to find each other, because we share families. There is nothing about a county or a State boundary that keeps a family within it.

If I live in Connecticut, work in New York, and my children live in New Jersey, and I'm beating and molesting them, there is no mechanism for the multiple agencies across State lines to find each other.

The only agency that seems to know how to do that is law enforcement. As mentioned earlier, that multi-State context seems to work better in terms of pursuing stolen cars.

My office is listed in the county phone book with the words "child abuse." So I, occasionally, will get a call from someone—it seems Ohio, or Nebraska, the Midwest in particular will say, "I need to find a family. They ran away with the kid from the foster home, and they are probably leaving with the sister."

I'll say, "You have the wrong number. Keep my number. I'll help you find the child protective service locally." And then they ask if someone under courtesy supervision will go and see how that family is doing. I think we can do better than ask individual line workers to heroically extend themselves.

Now, I have five recommendations that I think are fairly clearly outlined in my statement.

The need for central resource and leadership.

The need for State reports: My thought about the State report is that States, through reports that are being sent to the Federal Government should account for their activities involving child death intervention, specifically, child death review teams, any particular studies or protocols detailing the number of cases in that State. Then, the State couldn't say, we don't know. The State, in the end, would have to be accountable.

It impresses me that a high school football player who misses a block on Friday is required on Monday morning to sit down with a peer group and watch that missed block over and over and over again. If we can require that of teenage athletes, we can certainly require that of professionals and agencies involved with intervention with child abuse and neglect.

My third suggestion is that by 1994, the ante should be raised. I don't think a report saying we aren't doing much should be adequate in that year. My sense is that by that year, the majority of States will have at least a structure for a fairly thoughtful program.

The fourth recommendation is in reference to the President's Commission that I was appointed to. If that commission cannot be funded, at least the subtask of that commission to address fatal child abuse and neglect should be given to somebody and the resources should be given. Other people may have more information on who that somebody might be. My personal suggestion is the U.S. Advisory Board on Child Abuse and Neglect.

Let me end where I began, that I sent material in the past, and I will be sending more material in the future. I would appreciate any comments or advice the committee might give me in how I might be more effective.

[The prepared statement of Michael Durfee, M.D. follows:]

FATAL CHILD ABUSE AND NEGLECT

Testimony before the House Subcommittee on Select Education
Michael Durfee M.D. - February 27, 1992

A fragile young African American child is chronically neglected and beaten in a home with previously reported episodes of child abuse, domestic violence, and substance abuse. His mother has a criminal record and a violent boyfriend. Multiple agencies knew the family. No agency knew all of this history. The child dies a painful, tragic and unnecessary death.

This scenario is not uncommon. Child fatalities at the hands of a caretakers involve an over representation of: infants or young toddlers, poverty, racial minorities, substance abuse, previous family violence including domestic violence, and social isolation.

But, families of all races, ages, social economic status, and social profiles are represented.

The problems with these cases are compounded by what some see as a conflict between and among:

- necessary protection of confidentiality
- protection of agency integrity
- protection of the parents and family unit
- protection of children.

This in turn is complicated by the general lack of communication between agencies, particularly between the criminal justice system and health and social services.

Fatal child abuse, particularly of young children, becomes lost in the multiagency maze of service providers. The criminal justice system addresses homicide, but often separates itself from "child abuse", especially of infants and young toddler. Health systems treat infants and toddlers, but avoid issues of violence and perversion.
Social services agencies provide services to abusive families but have no proscribed role once the child is dead.

A growing number of counties and states are finding a way to manage these conflicts with multiagency teams working with the common goal of logically reviewing and managing cases of fatal child abuse and neglect.

The Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN) developed an interagency team in 1978 that now involves 14 agencies including private health providers as regular members. Cases are chosen from coroner's records with an attempt to find all potentially suspicious deaths. This team process provides a system of peer review that improves intra and inter-agency case management.

San Diego County formed a team in 1982 followed by other California counties and similar teams in South Carolina (1985), Missouri and Oregon (1986), Minnesota (1987), Franklin County, Ohio and Colorado (1988). The last few years have seen that total increase to 20 states with state or local teams covering a total population of 100 million people or about 40% of this nation

Another 16 states and the District of Columbia have at least a moderate level of activity planning such a team process. States that are already involved in the process are filling in gaps with teams at the state or local level. Oregon and Missouri will soon have state teams and teams in all counties. California and Georgia should soon follow with complete statewide networks.

Nationally this should reach half of the nations population and more than half of the states in 1992. Most team members work on or near the line and rapidly develop an appreciation for the value of interagency communication and accountability.

Some states have actively used legislation or mandates to build the process (Georgia, Missouri, North Carolina) Other states began the process before legislation (California, Oregon, Colorado). Some states began with state teams (South Carolina, Florida) Other states began with local teams (California, Ohio, Illinois).

All states seem headed in a similar direction with:

- state multiagency teams
- teams in urban counties
- expansion of local teams to cover all counties
- use of case review to improve intervention systems
- protocols for case management and data systems.
- a beginning focus on possible court or social sanctions
- a growing emphasis on all categories of preventable death
- a growing number of annual public reports

The multiagency forum with peer group accountability is more vigorous and effective than an individual agency can provide. This will require transcending artificial barriers of confidentiality that block information sharing necessary to protect children. An intake of an inclusive number of cases adds to that vigor with a review of all cases, not just the notorious case of the moment. Public reports provide material for future system planning and provide a public accountability of the child abuse intervention system.

Most states began with child protective service agencies reviewing their own cases in isolation. Pennsylvania has a state multiagency team but only reviews cases that people choose to bring to that team. New York City has a team with outside paid consultants but only reviews cases in the child protective service system.

Counties and states are gathering in dyads or clusters to share resources and to share interventions with cases that cross county and state lines. Coordinators bring these groups of states or counties together for meetings or to share data and resources.

National coordination has also been maintained by individuals and groups extending themselves to reach others.

- The National Center for Prosecution of Child Abuse in Fairfax Virginia has sponsored national conferences on fatal child abuse, provided resources through it's newsletter and mailings, and continues to coordinate the work of prosecutors nationally.
- The American Bar Association, with a grant from the Robert Wood Johnson Foundation, has provided consultation to state and local jurisdictions that request it. The ABA has developed a suggested minimal case data set.
- The United States Advisory Board on Child Abuse and Neglect has identified fatal child abuse as a key issue with support from Secretary Sullivan.
- Individual initiative is bringing the states together in clusters and the beginnings of a national system.

Federal representation is beginning with meetings of professionals from Health and Human Services and from the Department of Justice. The National Clearinghouse on Child Abuse and Neglect is gathering materials for distribution. The Department of Defense and the Indian Health Services are exploring their roles as direct service providers to children and families.

RECOMMENDATIONS

There has been expanding recognition of the need for multiagency review and accountability for child abuse fatalities. Adequate resources are needed to coordinate and encourage efforts nationally.

I. A central resource is needed to track and coordinate the various local, state, and national efforts in criminal justice, health, and human services with:

- **a directory of teams, resources, and expertise.**
- **a collection of protocols, studies, and laws**
- **a national data set including the FBI Uniform Crime Reports, Vital Statistics, and child abuse reports.**

Some components of this may be available with present resources in Federal agencies. Other components would need additional funding.

II. States receiving funds under the Child Abuse Prevention and Treatment Act should be required to provide an annual report of efforts to address fatal child abuse and neglect. The report should include comments on:

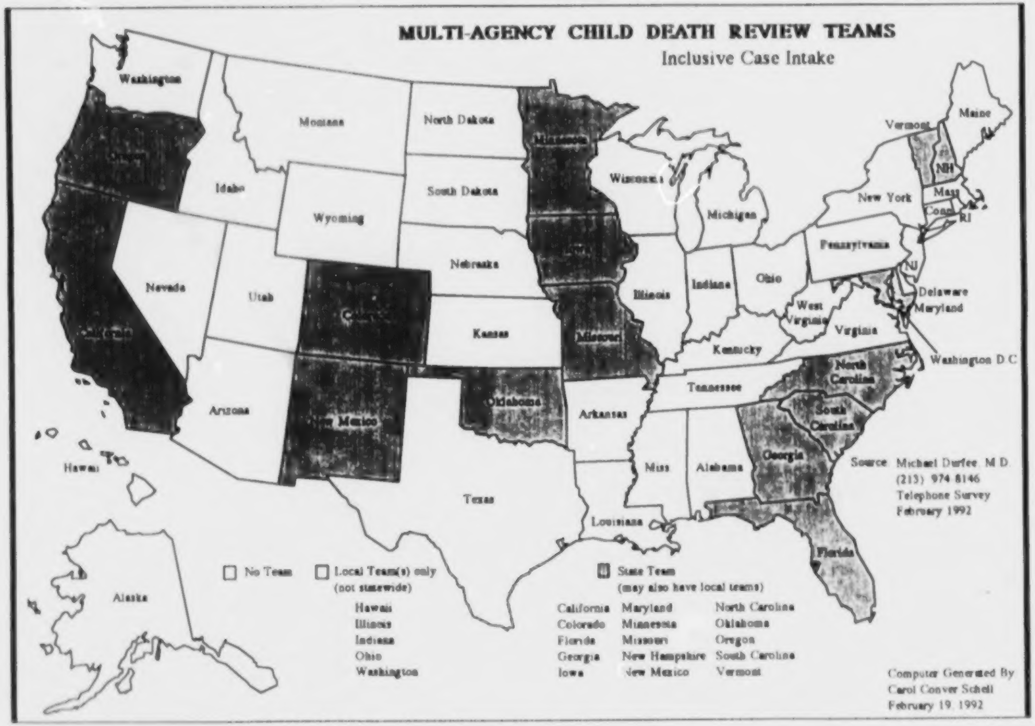
- **Multiagency teams**
- **Protocols and Studies**
- **Methods of multiagency information sharing - including addressing issues of confidentiality**
- **The incidence and profile of fatal abuse and neglect**

The report should be included with the existing requirements. States should not initially have to build programs but would need to be accountable for that deficit. The collection of state reports would then be made available to all states and interested parties.

III. By 1994, states should be required minimally to account for multiagency teams, protocols, and data reports.

IV. The CAPTA authorized Presidential Commission on Child And Youth Deaths should be funded. At a minimum, resources should be given to another body, such as the U.S. Advisory Board on Child Abuse and Neglect, to complete the critical tasks related to child abuse and neglect fatalities.

This Comission was authorized and members were appointed. Funds were never provided. The work still needs to be done.



MULTI-AGENCY CHILD DEATH REVIEW TEAMS

Inclusive Case Intake

Washington
Oregon
California
Nevada
Idaho
Montana
Wyoming
Utah
Arizona
Colorado
New Mexico
North Dakota
South Dakota
Nebraska
Kansas
Oklahoma
Texas
Minnesota
Iowa
Missouri
Arkansas
Louisiana
Wisconsin
Illinois
Michigan
Indiana
Ohio
Kentucky
Tennessee
Miss
Alabama
Georgia
Florida
South Carolina
North Carolina
Virginia
West Virginia
Pennsylvania
New York
Vermont
Maine
NH
Mass
Conn
RI
NJ
Delaware
Maryland
Washington D.C
Hawaii
Alaska

☐ No Team

☐ Local Team(s) only (not statewide)

- Hawaii
- Illinois
- Indiana
- Ohio
- Washington

▨ State Team (may also have local teams)

- California
- Colorado
- Florida
- Georgia
- Iowa
- Maryland
- Minnesota
- Missouri
- New Hampshire
- New Mexico
- North Carolina
- Oklahoma
- Oregon
- South Carolina
- Vermont

Source: Michael Durfee, M.D.
(213) 974-8146
Telephone Survey
February 1992

Computer Generated By
Carol Conver Schell
February 19, 1992

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Chairman OWENS. Thank you.

We're pleased to have Congressman Jones at this time. We'll proceed with the introduction of the Honorable Mary Margaret Oliver.

Mr. JONES. Thank you, Mr. Chairman, and I'm very pleased and honored to sit next to Mary Margaret Oliver, who represents the 53rd District in the Georgia State House of Representatives. I want to thank you for having these hearings on this most vital and most essential issue. I applaud your work.

I want to take this opportunity to introduce Mary Margaret. She was elected to the Georgia House in 1987. Among her other committee responsibilities, she chairs a Judiciary Committee Subcommittee on Child Protection Issues.

In August of 1989, she was appointed co-chairwoman of a study committee on Georgia's child welfare system. Well, after intensive review, this study committee proposed sweeping changes to Georgia's child welfare laws, and in 1990, she spearheaded a successful drive to pass a series of legislative proposals for the protection of children in our State.

In September of 1991, her outstanding work was recognized by the Health and Human Services Department's Administration on Children, Youth, and families, and she received the Commissioner's Award for the State of Georgia.

She has also served on the boards of several child advocacy organizations in our community. Her knowledge, expertise, and commitment to child protection issues will undoubtedly be helpful to your committee, as it reauthorizes the pending child abuse prevention legislation.

Mr. Chairman, I just want to say on a personal note, that Mary Margaret is one of the most gifted young legislators in the State of Georgia. She has been recognized as such. She is a no-nonsense legislator, and when it comes to children's issues, there is no better advocate in our State, and I don't think any finer or more gifted expert in our State on these issues.

I thank you for giving me the opportunity to introduce her.

Chairman OWENS. Thank you. Obviously, her schedule is quite a busy one. We are quite honored to have her here today.

Mr. JONES. She's missing votes.

Chairman OWENS. Please proceed.

Ms. OLIVER. Thank you, Mr. Chairman, very much.

As you alluded in your opening statement, the political energy in Georgia to review and examine Georgia's child welfare system was initiated by a series of articles written by Jane Hansen, a reporter with the Atlanta Journal/Constitution.

It was a remarkable piece of work by an investigative reporter, and it created a political energy under the leadership of then-Governor Harris, Lieutenant Governor Miller, and Speaker of the House Tom Murphy.

Our study committee was charged with examining why Georgia's children were dying, even though we were spending enormous sums and resources by Georgia's standards to prevent such deaths. The 51 unexplained deaths of Georgia's children was the focus of our inquiry. In making that focus, we determined that an analysis of Georgia's confidentiality statutes and how they interwove with the Federal statutory and regulatory system was essential.

Our study committee had public hearings and public testimony, and like all politicians, I think I occasionally fall into the unfortunate habit and trap of not listening carefully enough to public testimony.

On one day of our hearings, however, this complacency or political apathy was sharply and dramatically jarred. An elementary school teacher from Blairsville, Georgia, a small community in Georgia's Appalachian mountains, had called my office and asked to testify.

She was given a time on our public hearing agenda, and it was clear from her testimony that she came from a personal experience. She had never been politically active. She had never been to a hearing, and I don't believe she has ever come back to the capitol. I don't think even today she knows the impact of her story and her words.

She wanted to tell our committee about her experience with a child in her third grade class, a 9-year-old child, Jeannie. She had observed—because this is a small elementary school where the teachers all know the children—over a period of years, that this child had appeared repeatedly in her class, dirty, smelling badly, underfed, hungry.

And this child began to talk with this teacher about her worries about her younger sister, Charlene, who also was evidencing neglect. Jeannie expressed worry and concern about her mother's boyfriends, and how she was occasionally frightened.

This teacher began a series of actions to initiate with the local Department of Family and Children Services' child protective workers. She was repeatedly told, "We cannot share information about Jeannie's case with you because of confidentiality."

A few months after these series of efforts on her part, Jeannie was found raped, murdered, and thrown in a North Georgia river. Her murderer was arrested and convicted, and it was, in fact, one of her mother's boyfriends.

Jeannie's teacher had an impact on me and my fellow politicians. Our inquiry into the Georgia statutory framework brought us into a close analysis with the Federal statute and regulations.

Dr. Horn testified this morning about the 11 exceptions to the basic Federal policy of confidentiality of child abuse records. In my testimony exhibits, I have set forth references and citations to those regulations and Georgia case law and Georgia citations which really explain what the State view of the rights of privacy may be in relation to children, or in relation to children who are deceased, and how the State law distinguishes that issue.

Our legislation, which I have set forth in my exhibits, House Bill 1319, in attempting to comply with the Federal regulatory network, specifically attempted to make, by statute, a determination, a policy statement that teachers could be involved in the investigative, the supervisory team.

I think the role of the teacher in this regulatory system is very significant. The death of Adam Mann, the death of Yaakov Riegler in New York City, and the death of Jeannie all had evidence in the case files that a teacher had sought to intervene on behalf of that child.

The States are very inconsistent. The counties, even in Georgia, are very inconsistent, and we sought in House Bill 1319 to specifically state that a teacher was part of the supervisory investigative team to comply with our Federal regulations.

We also went further and made specific statutory policy statements in relation to information about children who are deceased. We stated, as you stated in your opening testimony, that Georgia thought it was appropriate policy and, we thought, consistent with the Federal regulations, that a very limited amount of information would be released from a file.

It is never appropriate, I believe, that the informant of child abuse be released. I do not believe that our statutory framework in Georgia, given our child fatality review team legislation which we did enact also—that in none of those instances is it necessary or required to reveal all the personal identifiers of the child, the family, the alleged perpetrator, and never the informant.

With those guidelines, however, I think that a statutory framework on a State level, with Federal regulatory permission, can be enacted to be accurately reflective of the Georgia State law or any State law in relation to issues of privacy.

In relation to the enactment of 1319, thereafter, I've set forth in the documents before you, a history of the bureaucratic dispute that has arisen with HHS in Georgia.

HHS is objective to Georgia's statute—the 1990 statute on confidentiality—stating it does not comply with the Federal regulations.

We made an attempt in 1991 to make certain corrections pursuant to a negotiation, but we determined, as a matter of policy—we politicians, that is—that information, very limited and very protected, relating to deceased children was something we were not going to back off of. We have, right now, between Georgia and the Federal Government, a stalemate, and a standoff.

I'm here today, when I should be at home in the Georgia General Assembly voting, to express my frustration at the Federal bureaucratic response to Georgia's attempt to make confidentiality statutes rational. It is my firm belief that confidentiality statutes and regulations enacted on a Federal level do far more to harm children than they could ever serve to protect.

Confidentiality statutes are used, in my opinion, to make the State and its agents less accountable to taxpayers for actions in those areas of government responsibility that are most critical: the lives of our children.

I personally believe—and I wish to state this to you most strongly—that the Federal Government's confidentiality statutes and regulations and the way in which they are forced cause children's deaths and do not prevent them.

Federal bureaucracy's attention to confidentiality is even more dramatic to me, as a lawyer and a legislator, when you compare the bureaucrat's inattention to Federal regulations which mandate that children involved in abuse and neglect hearings must be represented by a guardian ad litem.

Mr. Davidson specifically referred to the statutory and regulatory section that I refer to now, and we have, in the Georgia House now, a State statute, House Bill 180, that would confirm by State policy the Federal policy that already exists that guardian ad litems must be presented—must be in court—for neglected or abused children.

The Federal bureaucracy has chosen not to cite Georgia for that deficiency. It has never chosen to cite any State for that deficiency. Rather, its resources are in citing States for confidentiality abuses. I suggest to the chairman that that is a misplacement of Federal priorities.

I hope that you will do a comprehensive analysis of all child welfare statutes and resolutions. But if you wish to choose an area where your attention would be most beneficial and most significant, I urge you to make specific amendments to the statute and regulatory scheme as it relates to deceased children.

One, I believe that the Federal Government should specifically state in its statute and regulations that States have the authority to determine whether or not confidentiality protections apply or do not apply to children who are deceased.

The Federal Government, in our relationship in the bureaucratic dispute now, has determined that said regulations do apply to deceased children. I challenge them to make an argument, a policy argument, that that position serves the interests of that child who is dead. I think that that policy argument only serves to protect the State from lawsuits.

I think it is appropriate for you, in Congress, in its statute and regulations, to make a policy statement that states or authorizes to make exceptions to confidentiality in relation to children who are deceased, and I think 1319, as I've set forth in my exhibit, is one framework for doing that.

Secondly, I believe that the regulations and statutes should be changed to set forth, in essence a judicial bypass for release of confidential information. In one of the regulatory exceptions, information may be released for those entities doing legitimate research and data collection.

We determined, in our Georgia statutory network, since we knew that the free press and the media would be seeking information via that exception, to determine that juvenile courts should do a specific file review prior to the release of any documents.

We think that safeguards the ultimate purpose of protecting all of the parties and interests. I urge you to consider that as a statutory and regulatory option as you review confidentiality statutes.

In summary, I feel strongly that there is a specific and urgent need for Federal statutory and regulatory amendments which will create greater access for records relating to children who die while subject to ongoing child abuse investigations.

I believe that such amendments will serve the public good and, most importantly, save the lives of children who are most vulnerable.

Before I close, I wish to talk to you, politician to politician. Where Dr. Horn has 13, 23, or 26 staff to assist him, I have none. I serve in the Georgia General Assembly, like most State legislators, with no staff. I share a secretary with eight legislators.

We, on a State level, are totally vulnerable to the State and, more importantly, the Federal bureaucrats. Georgia is seeking to exercise leadership, under the leadership of Governor Harris and the leadership of Governor Miller.

We want to step forward. We want to serve this national debate of confidentiality. As a part-time politician, I am totally inadequate to fight the resources of all these staff people who are here today with all their aides. Please think of us, out in these States, who have inadequately funded programs and inadequate resources to do the battle.

I commend you on your hearings today. I hope that my exhibits and my testimony offer you some guidance, and I appreciate your concern. We want to be more accountable to our taxpayers, but more importantly, we want to help our most vulnerable and youngest citizens. Please help us.

[The prepared statement of Hon. Mary Margaret Oliver follows:]

TESTIMONY
OF
GEORGIA REPRESENTATIVE
MARY MARGARET OLIVER

February 27, 1992

COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE HEARING ON CHILD ABUSE
PREVENTION AND ADOPTION

APPENDIX

Exhibit I - Correspondence between United States Department
of Health and Human Services and Georgia Department
of Human Resources
July 11, 1990 - September 26, 1991

Exhibit II - Historical Analysis of Federal State; Legal Opinion
by Terry Adamson, Counsel for Atlanta Journal
Constitution
H.B. 1319

Exhibit III - "Suffer the Children" by Jane O. Hansen

Exhibit IV - Georgia Statutory and Case Citations
O.C.G.A. 49-5-41
O.C.G.A. 49-5-40
Napper v. Georgia Television Company
257-GA 156 (1987)
The Atlanta Journal and the Atlanta Constitution
v. Georgia Department of Human Resources, and
James Ledbetter - Civil Action No. D-73733

Exhibit V - Correspondence of Representative Mary Margaret
Oliver to Senators Sam Nunn and Wyche Fowler
Response from Louis Sullivan

My name is Mary Margaret Oliver and I was elected to the Georgia House of Representatives in 1987. In 1989 Jane Hansen, a reporter for The Atlanta Journal/Constitution, wrote an extraordinary series of articles on Georgia's child welfare system. Her news articles offered an indictment of Georgia's attempts to protect abused and neglected children at risk. Ms. Hansen also set forth a specific analysis of how federal and state laws and regulations relative to confidentiality of child abuse records served to endanger rather than to protect children.

Jane Hansen's articles focused, in part, on the unexplained deaths of 51 Georgia childen who were in the custody of Georgia's welfare system, or were subject to ongoing child abuse investigations and protective services. Clearly, these children's deaths were not prevented by the resources the State of Georgia deemed to appropriate for their care and protection.

In response to Ms. Hansen's articles relative to the deplorable state of Georgia's child welfare system, the Speaker of Georgia's House of Representatives, Tom Murphy, and the then Lt. Governor of the State of Georgia, Zell Miller, inaugurated as Georgia's Governor in 1991, appointed a Joint House Senate Study Committee on Georgia's child welfare laws. I was appointed by Speaker Murphy to serve as co-chairman of this legislative study effort.

A primary focus of our legislative inquiry, and an integral component of the testimony and evidence presented to us, related to Georgia's confidentiality statutes, and the method by which Georgia's statutes and the federal regulatory scheme prevented accountability of the bureaucrats for the protection of Georgia's children.

Like all politicians, I occasionally fall into the unfortunate habit and trap of not listening carefully enough to public testimony. On one day of our hearings, however, this complacency or politician apathy was sharply and dramatically jarred.

An elementary school teacher from Blairsville, Georgia, a small community in Georgia's Appalachian mountains, had called my office and asked to testify. She was given a time on the agenda, and it was clear that her testimony came from a personal heartfelt experience. She was not politically active, and she had never been to a hearing of any kind.

This teacher drove from the mountains to Atlanta to tell the House and Senate Study Committee about Jeannie, a child in her class. She had noticed for some time that this nine-year-old child often came to school hungry, smelled bad, and eventually confided that she was worried about her six-year-old sister, Charlene, also dirty and unfed. Jeannie worried, she told her teacher, because her mother partied with men who scared her.

This Blairsville teacher took the child's story to heart and called the local child welfare department to say she believed these children were living in danger. As Jeannie's concerns grew and nothing seemed to be happening, the teacher would again call the department and ask what they were doing to help. "I'm sorry," they would tell her, "We cannot tell you because of confidentiality." Some months later, Jeannie was raped, murdered, and thrown in a North Georgia river. Her murderer was captured, and convicted, and was in fact one of Jeannie's mother's boyfriends.

Jeannie's teacher had an impact on me and on our fellow Study Member colleagues. She went back to her classroom in the mountains, and probably does not know to this date the strength and impact of her words.

During Georgia's 1990 General Assembly Session, based on the momentum created by Jane Hansen's articles, and the resulting political energy, a package of legislation was passed impacting Georgia's child welfare system. Included in the package of seven bills was legislation (H.B. 1319) setting forth extensive revision of Georgia's confidentiality statute and creation of child fatality review committees in every county (H.B. 1318).

With the passage of House Bill 1319, a regulatory interpretation conflict between Georgia and the federal Department of Health and Human Services (HHS) began. I have attached all the correspondence relative to this bureaucratic dispute about whether or not Georgia's statute is in compliance with the federal regulatory scheme. I will not bother at this time in this testimony to go through in any detail the legal arguments relative to this dispute, because I believe they are set forth in the Exhibits to my testimony in detail.

The 1991 General Assembly Session, based on continuing conflict between HHS and Georgia over the newly-enacted confidentiality statute, passed amendments to House Bill 1319, which were set forth in House Bill 289. In essence, Georgia politicians determined it was best to attempt to satisfy the federal bureaucrats, and made some revisions and corrections in our 1990 legislation, which had attempted to provide limited access to child abuse investigative reports.

Despite our legislative efforts in 1991, however, federal bureaucrats were still not satisfied and demanded that we further amend Georgia's confidentiality statute. The specific conflict that still exists relates to a limited amount of information we determined would be released in relation to inquiries about deceased children. Specifically, the Georgia General Assembly passed legislation that said if a person called Georgia Department of Human Resources, and knew of the death of a child and the child's name, the Department would be allowed to answer two questions from that caller. First, was the child subject to a child abuse investigative report, and two, whether said child abuse investigative report was confirmed or unconfirmed. It is this specific legislative enactment by the Georgia General Assembly that the federal government continues to object to.

I am here today, when I should be at home in the Georgia General Assembly (where we are in session), to express my complete and utter frustration at the federal bureaucratic response to Georgia's attempt to make confidentiality statutes rational. It is my firm belief that confidentiality statutes and regulations enacted on the federal level do far more harm to children than they could ever serve to protect. Confidentiality statutes are used, in my opinion, to make the state and its agents less accountable to taxpayers for actions in those areas of government responsibility that are most critical - the lives of our children. I personally believe, and I wish to state this to you most strongly, that the federal government's confidentiality statutes and regulations and the way in which they are enforced cause children's deaths and do not prevent them.

Federal bureaucracy's attention to confidentiality is even more dramatic to me as a lawyer and a legislator when you compare the bureaucrat's inattention to federal regulations which mandate that children involved in abuse and neglect hearings must be represented by a guardian ad litem. Throughout our country, and certainly in Georgia, children go to court terrified and alone, without the protection of a guardian ad litem mandated by law. I have never heard of the federal bureaucracy initiating any effort to enforce provision of mandating guardian ad litems. Yet the confidentiality regulation is defended with the strength of armies. It looks like the government officials spend more time and energy defending the privacy rights of dead children than the legal rights of living children.

In our 1990 package of child protective legislation, an important component of our efforts related to child fatality review teams. Georgia's statute creates county by county interdisciplinary child fatality reviews and investigations of every child who dies in a suspicious manner. Every child under seven years old that dies by any accidental means, or any diagnosis of SIDS (Sudden

Infant Death Syndrome) shall be the subject of a child fatality review investigation. Georgia's child fatality review legislation and access to information for deceased children is what brings me to the specific recommendations I wish to make to you today.

I hope that you will do a comprehensive analysis of all child welfare confidentiality statutes and resolutions. But if you wish to choose an area where your attention would be most beneficial and most significant, I urge you to make specific amendments to statute and regulatory scheme as it relates to deceased children. I specifically recommend the following:

(1) Georgia's confidentiality statute relating to deceased children, Official Code Ga. 49-5-41(b)(2), serves the public interest and could serve as a basis for federal amendments.

(2) Federal statutes and regulations should provide specific authority for states to create exceptions to confidentiality statutes for children who are deceased, consistent with state laws of privacy and individual state policies.

(3) Federal statutes or regulations should provide specific authorization for states to create judicial opportunities for review of reports on file information prior to release to the public. Georgia's statutory approach requires the juvenile court judge to review files and documents prior to any public release. I would never support any confidentiality statute or regulatory change that would release the name of the reporter of child abuse. Nor would I ever support any legislation that would be in

conflict with state statutes in case law relative to confidentiality of ongoing criminal investigative reports.

Also, I do not support release of information to give the full name of the deceased child and the perpetrator, or to release any other identifiers to give personal information relative to the parties involved in any incidence. Rather, I think confidentiality statutes and regulations relating to deceased children should be amended for the limited purpose of greater accountability and greater oversight by our citizens and our free press.

In summary, I feel strongly that there is specific and urgent need for federal statutory and regulatory amendments which will create greater access for records relating to children who die while subject to ongoing child abuse investigations. I believe that such amendments will serve the public good, and most importantly save the lives of those citizens who are most vulnerable.

Before I close, I wish to talk to you politician to politician. Like most state politicians, I serve on a part-time basis, and I support myself the majority of my time in a full-time very active law practice. Like most state legislators I do not have a staff of any kind, and I do not have ongoing resources at my disposal to do careful investigation and research about the legislation for which I am responsible. It is absolutely impossible for a state legislator like myself to do battle with the federal bureaucracy. The level of frustration I have felt on this ongoing dispute with federal bureaucrats and the State Department of Human Resources is enormous. As a state legislator I am totally helpless in response to the power of the federal bureaucrat.

I have had many opportunities and privileges in my life. I have served as a judge in the state court system, as administrative hearing officer, and as administrative law judge. I've been a litigant in law reform efforts, and I have been a state legislator. All these experiences lead me to understand the power of the federal bureaucrat. I ask you to help us state legislators deal with these bureaucrats and the power they exert. Georgia is exercising leadership to prevent unnecessary deaths of our children by revising policies regarding confidentiality statutes and regulations. We want to be more accountable to our taxpayers, but more importantly to our most vulnerable and youngest citizens. Please help us.

EXHIBIT I

To: 9,851-[illegible] From: Off. of Human Development Svcs. 7-11-90 9:07am p. 2

ATTACHMENT NO. 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Office of Chief Counsel

Suite 521
101 Marietta Tower
Atlanta, Georgia 30323

DATE: July 11, 1990

FROM: Office of General Counsel
Region IV - Atlanta

SUBJECT: Georgia Child Abuse Legislation

TO: Nell P. Ryan
Regional Administrator
Office of Human Development Services
Region IV - Atlanta

Attention: Carol L. Osborne

This memorandum is in response to your request that we review recently enacted changes in Georgia's child abuse laws for compliance with eligibility requirements of the Child Abuse Prevention, Adoption and Family Services Act of 1988 (the "Act"), 42 U.S.C. §5106a(b). You were particularly concerned about whether the state legislation satisfied the confidentiality requirements of the Act. We conclude that the state statutes are clearly deficient as to confidentiality and have other potential deficiencies, depending on how state courts construe certain provisions.

The Act requires, among other things, that in order to qualify for a grant for prevention and treatment of child abuse and neglect, a state must "provide for methods to preserve the confidentiality of all records in order to protect the rights of the child and the child's parents or guardians." 42 U.S.C. §5106a(b)(4).

The applicable regulation, 45 C.F.R. §1340.14(i), permits states to authorize disclosure of reports and records concerning child abuse or neglect to several categories of persons and agencies: (1) an agency required by law to investigate reports of child abuse or neglect; (2) a court; (3) a grand jury; (4) an authority investigating a report or providing services to the child or family which is the subject of a report of child abuse or neglect; (5) a physician who has before him a child reasonably believed to be abused or neglected; (6) a person legally authorized to place an abused or neglected child in protective custody, if the information is necessary to the placement determination; (7) an agency authorized to diagnose, care for, treat, or supervise a reportedly abused or neglected child; (8) a person about whom such a report is made, so long as the release of information protects the identity of any reporting person who might be endangered by the disclosure; (9) an abused or neglected child named in a report; (10) a state or local official, carrying out an official function,

Memorandum to Neil P. Ryan
July 11, 1990
Page 2

of administering a child protective service or overseeing legislation related to such services; (11) an individual, agency, or organization conducting bona fide research, with several specified restrictions on the release of information (including a requirement that, before disclosure of the identities of individuals mentioned in the report, the child, through a representative, must first consent to the disclosure); and (12) additional persons or agencies "for the purpose of carrying out background and/or employment-related screening of individuals who are or may be engaged in child related activity or employment."

Georgia's amendments (H.B. 1319) to the confidentiality and disclosure provisions of Ga. Code Ann. §§49-5-40 and 49-5-41 generally require confidentiality but allow release of information from child abuse reports and records under numerous circumstances. As amended, sections 49-5-41(a)(5) and (6) permit release of some information about the status and results of an investigation "to any adult who makes a report of suspected child abuse" and to "[a]ny adult requesting information regarding investigations by the department or a governmental child protective agency regarding a deceased child when such person specifies the identity of the child." The federal regulation does not provide for such disclosures.

Amended section 49-5-41(a)(7) allows release of child abuse records upon a State Personnel Board's finding "that access to such records may be necessary for a determination of an issue involving departmental personnel." This disclosure provision is broader than what the federal regulation authorizes. The regulation, 45 C.F.R. §1340.14(i)(3), appears to limit such release of records to instances where "child related activity or employment" is at issue, but the state provision contains no such limitation and appears to allow disclosure any time the Personnel Board deems it necessary.

Further, Ga. Code Ann. §49-5-41(b) authorizes release of information for bona fide reseach purposes, but it does not appear to satisfy 45 C.F.R. §1340.14(i)(2)(xi)'s requirement of written consent before disclosure of the identities of individuals named in the reports and records released.

When an allegation of child abuse has been made against an employee of a school or child welfare agency, sections 49-5-41(c)(7) and (8) allow release of information to the school, the agency, and the employee. Federal regulations 45 C.F.R. §1340.14(i)(2)(vii) and (viii) allow such disclosure, but section 1340.14(i)(2)(viii) requires protecting the identities of persons making such reports, if the report is revealed to the person reportedly committing child abuse. The state statutes contain no such limitation.

wrong
A – mandated
[illegible]
execution

Two other state provisions pose potential problems but are not so clearly deficient as those discussed above. The regulations do not specifically address disclosure of records to or by state prosecutors. Certainly, such disclosures would in many circumstances be consistent with the goals of the Act and regulations to facilitate reporting, investigating, and remedying child abuse and neglect. Although 45 C.F.R. §§1340.14(i)(2)(i) and (iv) authorize disclosure to investigative agencies, they appear to do so within the confines of investigations of reports of abuse or neglect. Amended provisions Ga. Code Ann. §§49-5-41(a)(4) and 49-5-44(c) appear to put almost no limitations on a district attorney's access to child abuse records, other than job-relatedness, or his disclosure of such records in connection with a criminal prosecution. A liberal reading of section 49-5-41(a)(4) suggests that a prosecutor may gain access to records of prior child abuse reports merely for use in impeaching the credibility of, or showing a similar scheme by, the defendant in a wholly unrelated case.

Another potential problem area in the state statutes is that their definition of "child abuse" may not conform with the definition found in federal regulations. Basically, the state provisions define "child" to mean an individual under 18 years of age and "child abuse" to mean (a) "physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means"; (b) "neglect or exploitation of a child by a parent or caretaker"; (c) "sexual assault of a child"; or (d) "sexual exploitation of a child," defined as a parent or caretaker allowing the child to engage either in prostitution or in "sexually explicit conduct" for depiction in print or visual media.

Georgia's definitions create two problems. First, the definition of "child abuse and neglect" contained in 45 C.F.R. §1340.2(d) includes physical or mental injury, but Georgia's definition does not specifically encompass mental injury. Second, the federal regulation broadly defines sexual abuse (included in the definition of child abuse) to encompass incest, rape, molestation, prostitution, allowance of sexually explicit conduct for visual depiction, or "other form of sexual exploitation" involving an individual under 18 years of age. 45 C.F.R. §1340.2(d)(1). Although the meaning of "sexual exploitation" seems clear in Georgia's statutes, "sexual assault" is left undefined. Further, it is not defined in other statutes or state case law. Except for a criminal statute, irrelevant here, defining sexual assault on an institutionalized person (Ga. Code Ann. §16-6-5.1), Georgia's Code has no general definition or specific crime of sexual assault.

Assuming, for the sake of argument, that "sexual assault" encompasses all assaultive crimes of a sexual nature (including

Memorandum to Nell P. Ryan
July 11, 1990
Page 4

molestation, as it apparently must to satisfy 45 C.F.R. §1340.2), the crime of molestation (like statutory rape) by definition can only occur if the child is under 14 years of age. Ga. Code Ann. §§16-6-3 and 16-6-4. Thus, it is unclear what the relationship is between the crime of molestation and the term "sexual assault" used in the instant child abuse provisions, which define "child" as any person under 18 years (as they apparently must to satisfy the federal regulation, see 45 C.F.R. §1340.2(d)). If the term "sexual assault" incorporates the assaultive sex crimes and corresponding definitions found in Georgia's Criminal Code, it may not comply with the regulation, which appears to include molestation of any person under the age of 18 in the definition of "sexual abuse." Perhaps Georgia courts, if confronted with this apparent inconsistency in their statutes (defining "child" as one under the age of 18 in the definitions of "sexual assault" and "child abuse" but under 14 in the crime of molestation), would conclude that for purposes of criminal prosecution the age of consent is 14, but in the civil context of reporting, investigating, and intervening in instances of sexual abuse, "molestation" can involve victims in the 14 through 17 age group.

Possibly, an opinion from the Georgia Attorney General would clear up this uncertainty as to the meaning of sexual assault in such a way as to render the state definitions acceptable. The recent enactments, however, clearly fail to comply with confidentiality requirements mandated for federally funded state child abuse prevention programs.

Please let me know if you have any questions or if I can be of any further assistance.

Sincerely,

David Carpenter

David W. Carpenter
Assistant Regional Counsel

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Human
Development Services

Region IV
Suite 903
101 Marietta Tower
Atlanta GA

RECEIVED
JUL 23 1990
DIVISION OF FAMILY AND
CHILDREN SERVICES

JUL 18 1990

Douglas G. Greenwell
Director
Division of Family and Children Services
Department of Human Resources
878 Peachtree Street, N.E.
Atlanta, Georgia 30309

Dear Mr. Greenwell:

This is to advise that our Regional Office of General Counsel has reviewed recent legislative amendments made by the 1990 Georgia General Assembly to the child protective services reporting statute. The review indicates that the State's new laws are inadequate to meet the federal requirements specified in the Child Abuse Prevention, Adoption and Family Services Act of 1988.

The enclosed memorandum indicates the particular inadequacy of the state's confidentiality statute to meet federal requirements. Also, there are questions regarding definitions of sexual abuse and mental injury. You may want to seek official opinions from your State Attorney General to clarify and provide interpretations that may alter the state's present position of ineligibility. We suggest that prompt action be taken as national decisions will be made before the end of August, 1990 on state allocations.

Additionally, according to 45 CFR Section 1357.20, "The State agency must assure that with regard to any child abuse and neglect programs or projects funded under title IV-B of the Act, the requirements of paragraph (3) of Section 4 (b) of the Child Abuse Prevention and Treatment Act of 1974, as amended 42 U.S.C. Section 5103(b)(3) (Public Law 93-247) are met." This reference includes the requirement for confidentiality of all records. This may have implications related to the State's title IV-B funding.

Page 2

Please be assured that staff of the Children's Bureau is available to work with you and your staff in resolving these matters. Should you have questions, please contact Mrs. Carol L. Osborne at the above address or at 331-2128.

Sincerely,

Nell P. Ryan

Nell P. Ryan
Regional Administrator

Enclosure

J. 12

James G. Ledbetter, Ph.D./Commissioner
GEORGIA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF FAMILY AND CHILDREN SERVICES
878 PEACHTREE STREET, N.E. / ATLANTA, GEORGIA 30309

August 2, 1990

Ms. Nell P. Ryan
Regional Administrator
Office of Human Development
  Services
101 Marietta Tower, Suite 521
Atlanta, Georgia 30323

Dear Ms. Ryan:

I am in receipt of your letter dated July 18, 1990, regarding Georgia's newly enacted confidentiality legislation. I have discussed it with the Attorney General's staff. Please accept this letter as the Department's response to the issues identified.

First, let me assure you that in compliance with Section 5 of Act 1389 the Division will not release or allow inspection of any information if that inspection or release would result in the loss of any federal funds to the state.

Secondly, I will respond to your concerns in the order raised by David Carpenter, Assistant Regional Counsel in your Office of the General Counsel:

1. 49-5-41(a)(5) allows the state to tell a reporter of child abuse whether the investigation is completed and, if completed, whether child abuse was confirmed.

   This appears to the state to comply with 45CFR1340.14(i)(3) which allows the state to summarize the outcome of an investigation to the person or official who reported the abuse.

2. 49-5-41(a)(6) allows the state to tell any adult who knows the identity of a deceased child whether an investigation of the death is completed and whether child abuse was confirmed.

   The state agrees that federal regulations do not encompass this disclosure and will follow existing policy rather than the newly enacted legislation under the authority of 49-5-41 (Section 5) since disclosure would adversely affect federal funding.

3. 49-5-41(a)(7) allows release to the Georgia State Personnel Board without identifying any complainant or client by administrative subpoena when the Board finds the records are necessary for departmental personnel issues.

   The state agrees that federal regulations do not encompass this disclosure and will follow existing policy rather than the newly enacted legislation under the authority of 49-5-41 (Section 5) since disclosure would adversely affect federal funding.

4. 49-5-41(b) allows the state to disclose confidential information upon court order to individuals or entities engaged in legitimate research. It does not require release by the child or removal of identifying information prior to disclosure.

   The state agrees that federal regulations do not encompass this disclosure and will follow existing policy rather than the newly enacted legislation under the authority of 49-5-41 (Section 5) since disclosure would adversely affect federal funding.

5. 49-5-41(c)(7) allows the state discretionary disclosure of confidential child abuse records to a child welfare agency or a school when an employee has been investigated and a child remains at risk from continued exposure to that employee.

   This statute appears to comply with 45CFR1340.14(i)(2)(vii) which allows disclosure to an agency authorized by a constituted authority to diagnose, care for, treat, or supervise [emphasis added] a child who is the subject of a report or record of child abuse or neglect. Also, under the state's discretionary authority, it will not disclose identifying information about other parties obtained during the investigation.

6. 49-5-41(c)(8) allows the state discretionary authority to disclose its investigative findings to a school or child welfare agency when the school or agency's employee has been investigated, the Department has been unable to determine the employee's involvement in the alleged abuse and the employee has signed a release.

   This also appears to comply with 45CFR1340.14(i)(2).

Other issues which were identified as potential problems, but not presently in direct conflict with federal regulatory requirements, are addressed below:

1. 49-5-41(a)(4) allows disclosure to a district attorney or his assistant in connection with official duty when federal regulations do not address disclosure to or by state prosecutors.

   It appears to the state that 49-5-41(a)(4) complies with federal regulations because (1) 45CFR1340.14(b) allows the state, when defining child abuse and neglect, to adopt substantially similar language instead of requiring identical language. Therefore, it would appear that the state would have the same latitude with other substantially similar terms. (2) 1340.14(i)(2) allows disclosure to a properly constituted authority investigating abuse or neglect or providing services to a child or family which is the subject of a report. 1340.2 defines "a properly constituted authority" as including the police, the juvenile court or any agency thereof. The district atttorney would clearly fall under an agency of the court system, including the juvenile court system. Further, (3) a district attorney is an officer of the court and the court is allowed access under 1340.14(i)(2)(ii) and (4) the district attorney's office serves as an agency legally mandated by state law to receive and investigate reports of known and suspected child abuse and neglect. Finally, (5) 1340.14(i)(3) recognizes the authority of a state's laws or procedures concerning the confidentiality of its criminal court or its criminal justice system and does not infringe thereupon.

2. The definition of child abuse found at 49-5-40(a)(3) does not conform to federal regulations because it fails to include mental injury.

   Please refer to Attorney General's Opinions dated July 17, 1984, and April 9, 1985.

3. The definition of child abuse and neglect found at 49-5-40(a)(3)(C) does not conform to federal regulations because sexual assault is an enumerated element of child abuse at 49-5-40, but is not defined either there or in the criminal code and it does not mention molestation as an element.

Please refer to Attorney General's Opinion dated February 21, 1985, in which the Attorney General's Office found that sexual assault includes the element of child molestation.

4. There is a discrepancy between the age of the child protected under 49-5-40 and 41 (up to age 18) and the child victimized under the Georgia Criminal Code (up to age 14).

   Although the age used in the Georgia Criminal Code to define criminal acts against children is up to age 14, the Department is statutorily mandated to protect children up to age 18. Therefore, regardless of the actions taken by the prosecutorial community, child abuse victims as defined by 49-5-40 will continue to be served by the Department of Human Resources up to age 18.

Thank you for the opportunity to clarify Georgia's position with respect to the issues raised by General Counsel's Office. We look forward to a favorable response and continuation of our federal eligibility.

Sincerely,

Douglas G. Greenwell, Ph.D.
Director

DGG:ljb

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Office of Chief Counsel

Suite 521
101 Marietta Tower
Atlanta, Georgia 30323

CONFIDENTIAL - ATTORNEY-CLIENT COMMUNICATION

DATE: March 15, 1991

FROM: Office of General Counsel
Region IV - Atlanta

SUBJECT: Georgia Child Abuse Legislation

TO: Nell P. Ryan
Regional Administrator
Office of Human Development Services
Region IV - Atlanta

Attention: Carol L. Osborne

This is in response to your memorandum requesting our opinion on whether the confidentiality requirements of 45 C.F.R. §1340.14(i) apply to child abuse and neglect reports and records where the child who was the subject of the investigation covered in the documents is deceased.

The letter attached to your memorandum indicates that this request results from an inquiry by the Director of the Georgia Department of Human Resources' Division of Family and Children Services. David Carpenter, of this office, previously received clarification of the State's concern in this matter from Lynnda Jones, counsel for the State agency. This inquiry reportedly results from the Georgia news media's desire to have greater access to information in cases of suspected child-abuse murder. According to Ms. Jones, the State was reportedly considering legislation that would have allowed disclosing, to any individual identifying a deceased child by name, answers to two questions: (a) whether there was an investigation of suspected abuse or neglect as to that child and (b) whether the investigation confirmed that child abuse or neglect had occurred.

We have reviewed the applicable regulation and consulted with our central office. In our opinion there is no basis in the regulation for treating reports and records about child abuse or neglect any differently simply because the child reportedly abused or neglected has died.

The regulation states that "[t]he State must provide by statute that all [reports and records concerning reports] of child abuse and neglect are confidential and that their unauthorized disclosure is a criminal offense." 45 C.F.R. §1340.14(i)(1) (emphasis added). The general confidentially requirement of the regulation thus does not suggest an exception for cases in which the child abuse or neglect victim dies. Further, although States are permitted "to authorize by statute disclosure to any or all of the . . . persons or agencies [listed in sections 1340.14(i)(2)-1340.14(i)(5)], under limitations and procedures the State determines," the exceptions specified in the regulation neither state nor imply an exception for private citizens or members of the news media investigating the death of a suspected child abuse or neglect victim.

Ms. Jones expressed that proponents of the exception offer two main justifications: (1) that there is no need for confidentiality to protect the privacy of an individual who is now deceased; and (2) that limited release, such as mentioned above, minimizes the risks normally accompanying disclosure. The proponents' first justification fails to recognize that confidentiality requirements protect other family members, including siblings, and also those who report suspected abuse or neglect. As to the latter justification, the regulation allows just two exceptions for limited disclosure of specific information: (a) release for a bona fide research project, without disclosure of material identifying individuals named in the documents, unless a State official and the child, through a representative, consent to identifying information, 45 C.F.R. §1340.15(i)(2)(xi); and (b) disclosure of a summary of the outcome of an investigation to the person who reported the suspected abuse or neglect, 45 C.F.R. §1340.14(i)(4).

We conclude that 45 C.F.R. §1340.14(i) does not authorize an exception for a State's disclosure of child abuse and neglect reports and records about suspected victims who are now deceased, except for the limited circumstances mentioned above.

Sincerely,

David Carpenter

David W. Carpenter
Assistant Regional Counsel

DEPARTMENT OF HEALTH & HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES
Region IV

REFER TO: FSS CO (2134)

Douglas G. Greenwell, Ph. D.
Director
Division of Family and Children Services
Georgia Department of Human Resources
878 Peachtree Street NE
Atlanta, GA. 30309

Dear Dr. Greenwell:

Upon review of the legislation passed by the 1991 session of the Georgia General Assembly by our Regional Office of General Counsel, it has been noted that the State is not in compliance with federal requirements mandated by the Child Abuse Prevention, Adoptions and Family Assistance Act of 1988. At issue is the confidentiality of child abuse and neglect records.

As stated in the July 11, 1991 General Counsel review of Georgia's statute, section 49-5-4(a)(6) "... sections 49-5-4(a)(5) and (6) permit release of some information about the status and results of an investigation 'to any adult who makes a report of suspected child abuse' and to '[any adult requesting information regarding investigation by the department or a governmental child protective agency regarding a deceased child when such person specifies the identity of the child.' The federal regulation does not provide for such disclosures."

The Regional Attorney has advised that section 49-5-41(a)(G), added last year to section 49-5-41 by section 2 of H.B. 1319 (1990), apparently remains unchanged. It does not comply with the confidentiality requirements of 45 C.F.R. Section 1340.15(i). The Regional Attorney further has stated that "...By letter of August 2, 1990, the State informed us that it would follow the previously existing policy of nondisclosure, rather than 49-5-41(a)(6), pursuant to the saving clause in section 5 of H.B. 1319 (1990), which provided that the Act did not 'authorize or require loss of any federal funds to the state.' However, H.B. 289 (1991) specifically repeals the saving clause of section 5 of H.B. 1319 (1990)...." In order for further consideration to be made, the State needs to provide clarification as to whether or not it is still following the prior policy rather than section 49-5-41(a)(6) and if so, by what authority? If it is following the prior policy by authority of section 49-5-43, there is a need for clarification on the State's position on how the board may by policy nullify the specific language of section 49-5-41(a)(6) in light of section 49-5-42's authorization to "adopt rules and regulations not inconsistent with this article."

We will need clarification by the State no later than 10:00 a.m. on September 19, 1991, for further consideration to be made. If the State is found ineligible, it will not receive Fiscal Year 1991 basic Child Abuse and Neglect nor Children's Justice federal grant funds.

Should you have questions, please let us know.

Sincerely,

Suanne Brooks /s.
Suanne Brooks
Regional Administrator
Administration for Children
and Families

James G. Ledbetter, Ph.D./Commissioner

GEORGIA DEPARTMENT OF HUMAN RESOURCES

DIVISION OF FAMILY AND CHILDREN SERVICES
878 PEACHTREE STREET, N.E./ATLANTA, GEORGIA 30309

September 19, 1991

Ms. Suanne Brooks
Regional Administrator
Administration for Children
and Families
Department of Health and Human
Services
Atlanta, Georgia

Dear Ms. Brooks:

In response to clarification from your agency that Georgia law found at OCGA 49-5-41(a)(6) fails to comply with confidentiality provisions found at 45 CFR 1340.14(i) and the potential loss of federal funds based upon that clarification, the State of Georgia respectfully requests reconsideration on the following bases:

1) 45 CFR 1340.14(i) provides that all records concerning reports and reports of child abuse and neglect are confidential. OCGA 49-5-41(a)(6) protects those records and reports in keeping with 1340.14 and provides only that the Department will acknowledge whether there is an ongoing or completed investigation of a death of a child and, if completed, whether child abuse was confirmed or unconfirmed. It in no way breaches the privacy of any parties (child's parents, third parties or reporters) concerned in the investigation or produces the record or report thereof. **THE STATUTE PROVIDES ABSOLUTELY NO ACCESS TO THE RECORDS WHICH ARE CONFIDENTIAL UNDER EITHER FEDERAL STATUTE OR REGULATION.**

2) 45 CFR 1340.14 contemplates protecting the privacy of living children since it sets forth its purpose as being for the "protection and treatment of children. 49-541(a)(6) contemplates acknowledging information only where the child is deceased and protection and treatment are no longer issues.

3) 45 CFR 1340.14 contemplates protecting the privacy of the parties involved. 49-5-41(a)(6) breaches no privacy provisions since the identity of the child is known by the inquiring party at the time the inquiry is made.

In Waters v Fleetwood, 212 Ga 161 (1956), a newspaper published the picture of a deceased child who was found murdered in a body of water. The mother of the child sued on the basis that the newspaper had breached the privacy rights of the child. However, the newspaper prevailed. In its decision, the court said that where an incident is a matter of public interest, or the subject matter of a public investigation, a publication in connection therewith can be a violation of no one's legal right to privacy. Citing other cases, the court said that frequently, the public has an interest in an individual which transcends his right to be let alone and since the whole is greater than its component parts, private rights must often yield to public interest.

In re LR, Fla Cir Ct, No 90-59851 CA 05, December 17, 1990, and January 4, 1991 provides that in cases involving the death of a child as the result of abuse, neglect or abandonment, there shall be a presumption that the best interest of the child and the child's siblings and the public interest will be served by full public disclosure of the circumstances of the investigation of the death of the child and any other investigation concerning the child and the child's siblings.

It is irrational, given the national climate of accountability, for a state to allow confidentiality laws to emasculate its perceived role by its citizens as protector of children by being unable to confirm that it has investigated the death of a child who died under questionable circumstances. The public has a need and a right to know that the agency vested with responsibility for protecting children is accomplishing its mandate.

This is the dilemma which faces the Georgia General Assembly and the Department of Human Resources. While it grapples with the public's interest in protection of its youngest citizens, it also seeks to comply with all federal requirements for continued funding. It was not the intent of the State of Georgia to enact any legislation that conflicts with federal laws or regulations and would result in a loss of federal funds. In the event we cannot reach agreement on this issue, the State of Georgia will take necessary action to attempt to remedy the situation.

Sincerely,

Douglas G. Greenwell

Douglas G. Greenwell, Ph.D.
Director

DGG:ljb

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES

Region IV

REFER TO: FSS CO (2134)

URGENT

Douglas G. Greenwell, Ph. D.
Director
Division of Family and Children Services
Department of Human Resources
870 Peachtree Street NE
Atlanta, GA 30309

Dear Dr. Greenwell:

After consultation with our Regional and Headquarters Offices of General Counsel, we must advise that the information in your correspondence dated September 19, 1991, does not meet the eligibility requirements for child abuse and neglect grant funds for Fiscal Year 1991. Georgia's statute, section 49-5-4(a)(6) which permits release of information about the status and results of an investigation "...to any adult requesting information regarding investigaion by the department or a governmental protective agency regarding a deceased child when such person specifies the identity of the child...." does not meet requirements of 45 C.F.R. Section 1340.14(i).

Should you have further questions, please advise.

Sincerely,

Suanne Brooks

Suanne Brooks
Regional Administrator
Administration for Children
and Families

James G. Ledbetter, Ph.D. / Commissioner
GEORGIA DEPARTMENT OF HUMAN RESOURCES
47 TRINITY AVENUE, SW / ATLANTA, GEORGIA 30334-1202

September 25, 1991

SEP 23 1991

BY FAX AND BY REGULAR MAIL

Ms. Suanne Brooks
Regional Administrator
Administration for Children and Families
Office of Human Development Services
101 Marietta Tower, Suite 821
Atlanta, Georgia 30323

Re: Denial of Grant Under the Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5106a

Dear Ms. Brooks:

This is in follow-up to my letter to you dated September 20, 1991. In that letter the Department asked for a meeting to discuss the position of the State of Georgia in the above-referenced matter. In the event that the matter cannot be resolved, however, I respectfully request clarification concerning your allocation of funds in order to protect Georgia's claim to these much needed monies.

I understand that the funds involved are grants to states for developing child abuse and neglect treatment programs pursuant to 42 U.S.C. § 5106a. I understand that the implementing regulations governing the administration of these grants are found at Part 1340 of 45 C.F.R. and that the allocation of these funds is done pursuant to 45 C.F.R. § 1340.11. If there is other authority upon which your agency relies, please let us know.

One provision of the implementing regulations would appear to make all grants under Part 1340 subject to the administration of grants provisions of 45 C.F.R. Part 74 and to the appeals provisions under the departmental grant appeals board found at 45 C.F.R. Part 16. See 45 C.F.R. § 1340.3. Nevertheless the jurisdiction of the Grant Appeals Board turns to some extent on

GEORGIA DEPARTMENT OF HUMAN RESOURCES
James G. Ledbetter, Ph.D./Commissioner
DIVISION OF FAMILY AND CHILDREN SERVICES
878 PEACHTREE STREET, N.E./ATLANTA, GEORGIA 30309

September 26, 1991

Ms. Suanne Brooks
Regional Administrator
Administration for Children and
  Families
Office of Human Development
  Services
101 Marietta Tower, Suite 821
Atlanta, Georgia 30323

Dear Ms. Brooks:

Based upon your most recent correspondence regarding Georgia's ineligibility for fiscal year 1991 basic Child Abuse and Neglect and Children's Justice federal grant funds, the State wishes to request reconsideration on the following grounds:

1. In 1990 the Child Fatality Protocol Committee was enacted. It provided that all deaths of children in the State would be reviewed and that all records and reports which became part of that review would be confidential.
2. A saving clause was enacted as part of this legislation. It provided that nothing in the Act shall be construed to authorize or require the inspection of any records or the release of any information if that inspection or release would result in the loss of any federal funds to the State.
3. This saving provision was not removed during the 1991 Session.
4. The child abuse and neglect records of all deceased children in Georgia become part of each child fatality review process.

It is our position that these records are confidential and not subject to disclosure under this law. Therefore, the State of Georgia respectfully requests award of the child abuse and neglect and justice funds on the basis of our continued compliance with federal regulations.

Sincerely,

Douglas G. Greenwell

Douglas G. Greenwell, Ph.D.
Director

DGG:ljb

EXHIBIT II

Child Abuse and Neglect

.1990 legislative session, General Assembly revised confidentiality laws

.7-18-90 received notice from HHS that certain provisions of our law did not meet federal regulatory requirements

.Based upon the threat of loss of federal funds DHR on 8-2-90 DHR informed HHS that we would invoke the saving clause enacted to protect federal funds.

.During the 1991 session additional changes were made to the confidentiality laws. However, the provision regarding information about deceased children was not changed and the saving clause in the confidentiality of child abuse records was removed.

.In January, 1991 DHR requested clarification regarding whether federal regulations was pertinent to deceased children and the federal fiscal impact if GA remained out of compliance with NCCAN eligibility requirements

.HHS responded in April 1991 (after the end of the session) that our statute failed to meet federal requirements

.In Sept 1991 DHR was informed by telephone that HHS was reviewing the 1991 version of our confidentiality statute and requested assurance that we would rely upon the saving clause in OCGA 49-5-43.

. Telephone conversations and correspondence occurred between DHR and HHS

. Regional HHS staff met with Central Office HHS and informed DHR on Sept 26 that GA would be deemed ineligible for NCCAN funding unless saving clause(s) was invoked

HISTORICAL PERSPECTIVE ON DECEASED CHILDREN

The General Assembly, during the 1990 legislative session, revised the confidential provisions for the child abuse and neglect records to provide for greater public accountability of the child abuse programs. Following the legislative session in 1990, the Regional Office of HHS contacted the Division to advise us that certain of our statutory provisions enacted in 1990 did not meet federal regulatory requirements. We met with the HHS staff and David Carpenter, Regional Office General Counsel staff, and managed to resolve most of the identified exceptions.

One which was not resolved was the issue raised by HHS that we failed to comply by providing reports or records of child abuse for a deceased child when asked by a member of the general public to do so. In fact, our statute provided that when a person inquired about a particular deceased child by name, the Department would acknowledge whether we had investigated the death for possible child abuse and if so, whether we had confirmed child abuse. No records were to be shared, no additional information provided.

Based upon the threat of loss of federal funds by HHS, at that time the Department provided HHS assurances in writing that we would rely upon the saving clause enacted with the provision in order to protect our federal funds. The saving clause was enacted because we had argued successfully during the session that federal funds would be jeopardized if the provision was enacted as written.

Following that, we returned to Representative Oliver at the time of the 1991 session with proposed changes which would comply with the federal regulation. The Atlanta Journal/Constitution and the Georgia Press Association actively opposed change of this provision. Representative Oliver incorporated many of the changes into amended legislation, but the House Judiciary Committee recommended that the provision regarding information about deceased children not be changed and the saving clause was removed.

During the session, at the request of Representative Oliver, we officially asked HHS to provide formal advice on the status of state compliance should this provision remain unchanged in Georgia law. Following the session, HHS provided a letter which stated that the Regional General Counsel's Office in consultation with Central Office General Counsel's Office had determined that our statute failed to meet federal requirements.

In mid-September two telephone calls were made by HHS advising DFCS that they were reviewing the 1991 version of our confidentiality statutes and were concerned that not only had the law regarding deceased children not been changed, but that the saving clause had also been removed. They asked at that time for a letter similar to the previous year's letter advising them that we would rely upon the saving clause found at OCGA 49-5-43, and we were given a 24-hour deadline to submit it.

At our request, HHS then followed their telephone request with a letter advising us that our statutory provision on deceased children did not comply with federal regulations and that in order to be eligible for federal child abuse and neglect funds we must clarify our position by 10:00 a.m. the following day. DFCS provided clarification by the deadline and were advised the same day that our clarification was inadequate.

Following that advice, Cindy Wright of the Governor's Office, Representative Oliver, Commissioner Ledbetter, Doug Greenwell, Peter Canfield, attorney for the Georgia Press Association, and staff from DFCS met with the Attorney General and his staff. Therefore, attendant to that meeting, a letter was prepared to Suanne Brooks asking for a meeting on the issues and information regarding appeal rights.

DOW, LOHNES & ALBERTSON

ATTORNEYS AT LAW

[illegible]

ONE RAVINIA DRIVE
SUITE 1600
ATLANTA, GEORGIA 30346-2103
—
[illegible]

[illegible]

January 25, 1991

BY HAND DELIVERY

Hon. Mary Margaret Oliver
Judiciary Committee
Georgia House of Representatives
State Capitol
Atlanta, GA 30334

Re: House Bill No. 289

Dear Rep. Oliver:

Just a year ago, we were afforded a much-appreciated opportunity to participate on behalf of The Atlanta Journal and Constitution in the Judiciary Committee's careful and deliberate consideration of your proposals to amend the confidentiality laws governing the State's child protection system.

Because of your perseverance and leadership, the Committee, the House and the General Assembly as a whole correctly recognized that these confidentiality laws have in the past served less to protect children and their families than to shield from public scrutiny the system's failures.

The Journal and The Constitution strongly endorsed and applauded last year's legislative improvements in the confidentiality laws for just this reason. As you recognize, it is the nature of our democratic system that things get done not just because they should get done but because people demand that they get done. Victims of wrongs of all stripe have the right to petition this body for action and to raise their voices high until they get not only laws but results. But this has never been and never will be the case with our children. A child cannot write his legislator to complain of abuse. A child cannot contact a newspaper reporter to complain that a government agency that is supposed to be protecting her is not doing its job. To redress and continue to redress the violence and abuse that is perpetrated on children we have to depend not only on government

BEST COPY AVAILABLE

but on the public scrutiny that ensures that government effectively functions.

We write now because of our strong belief that Section 2 of House Bill No. 289, evidently drafted by the Department of Human Resources and its Division of Family and Children Services, signals a significant retreat from last year's improvements.

By its Section 2, House Bill No. 289 seeks to rewrite O.C.G.A. § 49-5-41(b), a provision enacted last session that furnished for the first time in Georgia a procedure whereby "individuals or entities who are engaged in legitimate research for educational, scientific, or public purposes" may attempt to convince a juvenile court judge to afford access to records of child abuse.

Notwithstanding what you may have been led to believe, this so-called "research" provision, which D.H.R. began lobbying to change and administratively refusing to enforce less than six months after its enactment, was not 'slipped' into last year's legislation by the media. To the contrary, it was, en toto, the product of a conscious and deliberate compromise, drafted by the Governor's Office, between D.H.R. and news organizations. In addition, it was extensively discussed in at least one Judiciary Committee hearing in which representatives of the Georgia Press Association, The Atlanta Journal and Constitution, the Governor's Office and D.H.R. participated.

Not surprisingly, the provision was by no means at the time of its enactment, and is not now, a radical measure. Although a substantial step forward in Georgia, it is, in fact, a comparatively narrow statute nationally. As we wrote you last year, the statutes of over twenty states provide for researcher access to child abuse records. See Ala. Code § 26-14-8(b) (1986); Am. Samoa Code Ann. § 45.2023 (1988); D.C. Code Ann. § [illegible] 2114 (1981); Fla. Stat. Ann. § 415.51 (Supp. 1988); Ind. Code Ann. § 31-6-11-18(b) (Burns 1987); Iowa Code Ann. § 235A.15 (West Supp. 1988); La. Rev. Stat. Ann. § 46.56(F)(5) (West 1982 & West Supp. 1989); Me. Rev. Stat. Ann. tit. 22, § 4008(2)(F) (Supp. 1988); Mich. Comp. Laws Ann. § 722.627(a)(i) (West Supp. 1988); Miss. Code Ann. § 43-21-261 (Supp. 1988); Mo. Rev. Stat. § 210.150(1)(3) (Supp. 1989); Nev. Rev. Stat. § 432B.290 (1987); N.J. Stat. Ann. § 9:6-8.10a(1)(b)(8) (Supp. 1989); N.Y. Soc. Serv. Law § 422(4)(h) (McKinney Supp. 1989); N.D. Cent. Code § 12.1-35-03 (Supp. 1989); Ore. Rev. Stat. § 418.770 (1987); S.C. Code ann. § 20-7-690(C)(4) (Supp. 1988); Tenn. Code Ann. § 37-1-612 (Supp. 1988); Utah Code Ann. § 62A-4-513(1) (Supp. 1988); Wash. Rev. Code Ann. § 26.44.070 (Supp. 1989); Wis. Stat. Ann. § 48.981(7) (West. Supp. 1988). See also Minn. Stat. Ann. §

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609.1471 (West Supp. 1989). Only one of these over twenty states -- Mississippi -- has a provision like that legislated last year in Georgia conditioning such access upon case-by-case judicial approval. Miss. Code Ann. § 43-21-261 (Supp. 1989).

Similarly, and, again, unlike a number of other states' statutes and contrary to what you have undoubtedly been led to believe, it cannot be overemphasized that the Georgia provision now in effect does not permit public disclosure of so-called "identifiers." To the contrary, it specifically requires researchers afforded access to child abuse records to affirm, and the court to order, that information identifying children, reporters, individuals investigated but not charged, etc., not be disclosed. O.C.G.A. § 49-5-41(b)(2)(B). It also expressly confers upon the court continuing jurisdiction to enforce this order with contempt, O.C.G.A. § 49-5-41 [illegible], a sanction that I submit in the real world has many more teeth than the misdemeanor provision presently governing improper disclosure of child abuse records by D.H.R., O.C.G.A. § 49-5-44(a).

Finally, and with all due respect to the at best self-serving legal determinations of line personnel at D.H.R. and their compatriots at the federal Department of Health and Human Services, the present Georgia provision in no way violates federal confidentiality standards.

It must be noted, as H.H.S. officials have admitted, that these federal standards implicate, at most, some $350,000 in federal funds, not some $20 million as Georgia D.H.R. officials have suggested. It must also be noted that these federal standards are rarely enforced. Despite a number of long-standing state statutes much less restrictive than that enacted in Georgia last year, H.H.S. has cut off state funds for failure to comply with federal confidentiality standards only once in the program's fifteen year history. Moreover, outside the confidentiality area, Georgia is clearly out of compliance with a federal standard requiring the state to ensure the appointment of a special representative for each child who goes into court for a neglect or abuse hearing. Yet the federal government has made no threat to cut off funds to Georgia as a result.

Most importantly, however, even assuming that for some reason the federal standards will now be vigorously enforced, the present Georgia provision plainly complies. There is, as D.H.R. and others have noted, a federal confidentiality standard governing non-court-ordered access to child abuse records that permits researcher access to so-called "identifiers" only with the permission of a representative of the child. 45 C.F.R. § 1340.14(i)(2)(xi). Thus, it is true that if the present Georgia

[illegible]
H. 289

provision simply left the access decision up to D.H.R., this standard would be implicated and federal funding theoretically jeopardized. However, the present Georgia provision does not leave the access decision up to D.H.R. To the contrary, the researcher must petition and convince a court. For this reason, the provision falls under and fully complies with a separate federal confidential standard, discussed at the time of last year's compromise but entirely ignored by D.H.R. in its efforts since, that permits court-ordered access. 45 C.F.R. 1340.14(i)(2)(iii) (allowing disclosure to and by "a court" under terms identified in State statute").

For all of these reasons, we urge you to consider striking Section 2 of D.H.R.'s House Bill No. 289. The present Georgia "research" provision, which D.H.R. 'signed off on' less than a year ago, is conservative in nature and fully complies with federal funding standards. Moreover, unlike the alternative proposed by D.H.R. in Section 2, the present Georgia provision affords a meaningful opportunity for legitimate public scrutiny of a child welfare system desperately in need of such scrutiny. The present Georgia provision rationally prohibits public disclosure only of information that would identify "reporters of child abuse," or "a child," or "individuals who were investigated but not charged with or prosecuted for a crime," etc. D.H.R.'s Section 2, by contrast, would prohibit not only public disclosure of, but also any legitimate researcher access to, any identifying information whatsoever, including information identifying D.H.R. caseworkers. As a result, it would give D.H.R. virtually carte blanche to 'sanitize' its records in such a way as to frustrate attempts to hold it and its officials and employees publicly accountable.

For this reason, should you remain convinced that the present statutory provision should be changed, we would urge you to at the very least reject the new D.H.R. formulation in favor of one that would prevent this result. This could be accomplished, for example, by striking lines 110 through [illegible] of D.H.R.'s proposed Section 2 and substituting the following in their place:

> (3) Names and addresses of individuals, other than officials, employees or agents of agencies receiving or investigating a report of abuse or treating a child or family which is the subject of a report, shall be deleted from any information released pursuant to this subsection unless the court determines that having the names and addresses open for review is essential to the research and the child, through his/her representative, gives permission to release the information.

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We greatly appreciate your continued efforts to reform the child welfare system. We urge you, however, to reconsider your support for House Bill No. 289's Section 2.

Thank you for your consideration.

Sincerely,

Peter

Terrence B. Adamson
Peter C. Canfield

cc: Members of the House Judiciary Committee
Mr. Hyde Post
Ms. Jane Hansen
Ms. Kathy Berry
Mr. David Hudson

____________________________ offers the following substitute to HB 1319:

A BILL TO BE ENTITLED

AN ACT

To amend Article 2 of Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to child abuse records, so as to provide for definitions; to change the persons having access to such records and information contained therein and provide conditions for certain disclosures; to prohibit certain conduct relating to such records and information contained therein and provide penalties therefor; to provide immunity for certain disclosures; to prohibit certain information from being made a part of records which are open to the public and provide an exception; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

Section 1. Article 2 of Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to child abuse records, is amended by striking Code Section 49-5-40, declaring certain records to be confidential, and inserting in its place a new Code section to read as follows:

"49-5-40 (a) As used in this article, the term:

(1) 'Abused' means subjected to child abuse.

(2) 'Child' means any person under 18 years of age.

(3) 'Child abuse' means:

(A) Any physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means;

(B) Neglect or exploitation of a child by a parent or caretaker thereof;

(C) Sexual assault of a child; or

(D) Sexual exploitation of a child.

(4) 'Sexual exploitation' means conduct by a child's parent or caretaker who allows, permits, encourages, or requires that child to engage in:

(A) Prostitution, as defined in Code Section 16-6-9; or

(B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

(b) Each and every record concerning reports of child abuse ~~and neglect~~ and child controlled substance or marijuana abuse which is in the custody of the department or other state or local agency is declared to be confidential, and access thereto is prohibited except as provided in Code Section 49-5-41 and Code Section 49-5-41.1."

Section 2. Said article is further amended by striking Code Section 49-5-41, relating to persons permitted access to child abuse records, and inserting in its place the following:

"49-5-41. (a) Notwithstanding Code Section 49-5-40, the following persons or agencies shall have reasonable access to such records concerning reports of child abuse ~~and deprivation~~:

(1) A legally mandated, public or private, child protective agency of this state or any other state bound by similar confidentiality provisions and requirements which is investigating a report of known or suspected child abuse ~~or deprivation~~ or

treating a child or family which is the subject of a report or record;

(2) A court, by subpoena, upon its finding that access to such records may be necessary for determination of an issue before such court; provided, however, that the court shall examine such record in camera, unless the court determines that public disclosure of the information contained therein is necessary for the resolution of an issue then before it and the record is otherwise admissible under the rules of evidence;

(3) A grand jury by subpoena upon its determination that access to such records is necessary in the conduct of its official business; ~~and~~

(4) A district attorney of any judicial circuit in this state or any assistant district attorney who may seek such access in connection with official duty~~.~~ ;

(5) Any adult who makes a report of suspected child abuse as required by Code Section 19-7-5, but such access shall include only notification regarding the child concerning whom the report was made, shall disclose only whether the investigation by the department or governmental child protective agency of the reported abuse is ongoing or completed and, if completed, whether child abuse was confirmed or unconfirmed, and shall only be disclosed if requested by the person making the report; and

(6) Any adult requesting information regarding investigations by the department or a governmental child protective agency regarding a deceased child when such person specifies the

identity of the child, but such access shall be limited to a disclosure regarding whether there is such an ongoing or completed investigation of such death and, if completed, whether child abuse was confirmed or unconfirmed.

(b) The department or a county or other state or local agency may permit access to ~~such~~ records concerning reports of child abuse ~~and--deprivation~~ and may release information from such records to the following persons or agencies when deemed appropriate by such department:

(1) A physician who has before him a child whom he reasonably suspects may be abused ~~or deprived~~;

(2) Police or any other law enforcement agency of this state or any other state or any medical examiner or coroner investigating a report of known or suspected child abuse ~~or-deprivation~~;

(3) A person legally authorized to place a child in protective custody when such person has before him a child he reasonably suspects may be abused ~~or--deprived~~ and such person requires the information in the record or report in order to determine whether to place the child in protective custody; ~~and~~

(4) An agency or person~~,-other-than-a-child's parent--or--guardian,~~ having the legal custody, responsibility, or authorization to care for, treat, or supervise the child who is the subject of a report or record~~.~~ ;

(5) An agency, facility, or person having responsibility or authorization to assist in making a judicial determination for the child who is the subject of the report or record of child abuse,

including but not limited to members of officially recognized citizen review panels, court appointed guardians ad litem, certified Court Appointed Special Advocate (CASA) volunteers who are appointed by a judge of a juvenile court to act as advocates for the best interest of a child in a juvenile proceeding, and members of a county child abuse protocol committee or task force;

(6) A legally mandated public child protective agency or law enforcement agency of another state bound by similar confidentiality provisions and requirements when, during or following the department's investigation of a report of child abuse, the alleged abuser has left this state;

(7) A child welfare agency, as defined in Code Section 49-5-12, or a school where the department has investigated allegations of child abuse made against any employee of such agency or school and any child remains at risk from exposure to that employee;

(8) An employee of a school or employee of a child welfare agency, as defined in Code Section 49-5-12, against whom allegations of child abuse have been made, when the department has been unable to determine the extent of the employee's involvement in alleged child abuse against any child in the care of that school or agency. In those instances, upon receiving a request and signed release from the employee, the department may report its findings to the employer; and

(9) Any person who has an ongoing relationship with the child named in the record or report of child abuse any part of which is to be

disclosed to such person but only if that person is required to report suspected abuse of that child pursuant to subsection (b) of Code Section 19-7-5, as that subsection existed on January 1, 1990.

Section 3. Said article is further amended by striking Code Section 49-5-44, relating to penalties for allowing unauthorized access to certain records, and inserting in its place a new Code section to read as follows:

"49-5-44. (a) Any person who authorizes or permits any person or agency not listed in Code Section 49-5-41 to have access to such records concerning reports of child abuse ~~and--deprivation~~ declared confidential by Code Section 49-5-40 shall be guilty of a misdemeanor.

(b) Any person who knowingly and under false pretense obtains or attempts to obtain records or reports of child abuse declared confidential by Code Section 49-5-40 or information contained therein except as authorized in this article or Code Section 19-7-5 shall be guilty of a misdemeanor.

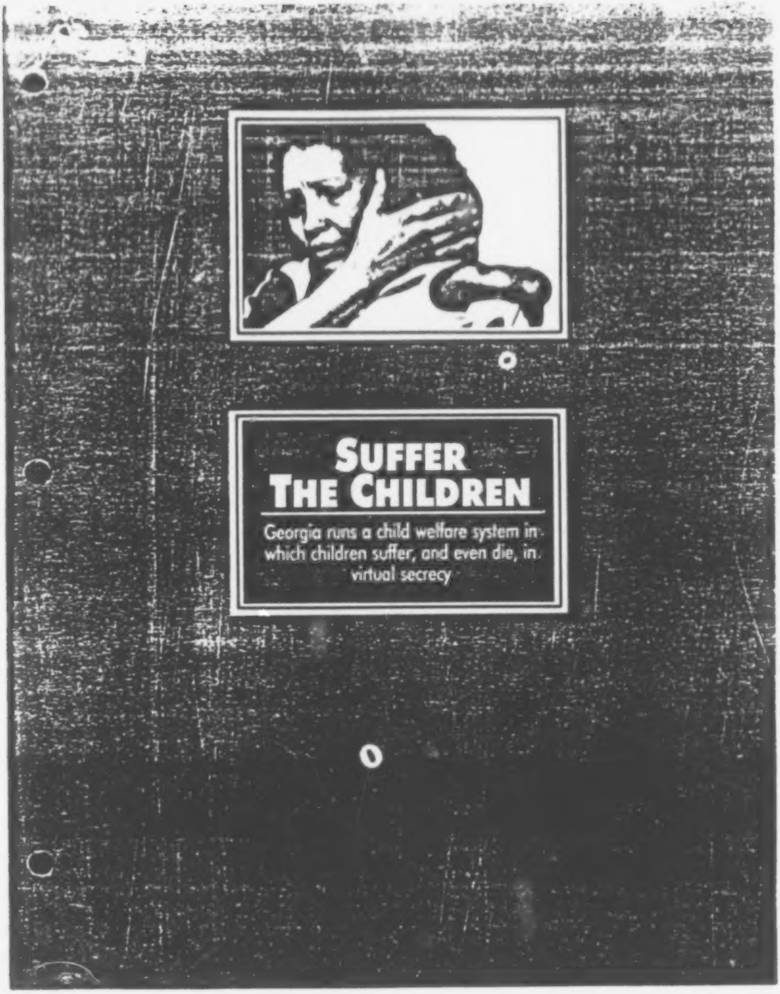
(c) Records made confidential by Code Section 49-5-40 and information obtained from such records may not be made a part of any record which is open to the public except that a district attorney may use and make public that record or information in the course of any criminal prosecution for any offense which constitutes or results from child abuse."

Section 4. Said article is further amended by adding at the end a new Code section to read as follows:

"49-5-46. The department or any agency and employees of either providing access to or disclosure of records or information as authorized by Code Section 49-5-41 shall have no civil or criminal liability therefor."

Section 5. All laws and parts of laws in conflict with this Act are repealed.

EXHIBIT III



SUFFER THE CHILDREN

Georgia runs a child welfare system in which children suffer, and even die, in virtual secrecy

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Something Has To Be Done About Georgia's Abuse of Children

The stories contained here are often painful to read. Usually, the public is not exposed to the intimate suffering of abused and neglected children. Usually, confidentiality rules assure that child welfare decisions are made behind closed doors.

Staff writer Jane O. Hansen opened those doors in her series, "Suffer the Children." She revealed a world where confidentiality often does more to cover the failures of the bureacracy than to protect the privacy of child victims, where being rescued from an abusive natural home is sometimes just a prelude to abuse in a foster home.

Her findings were compelling and disturbing:

■ Fifty-one children in Georgia died last year while under the "protection" of the state's child welfare system. One example: two toddlers whose drug-addicted father took them for a walk one evening and bashed their heads to the pavement; for eight months before the incident, the family had been the subject of repeated complaints to child welfare authorities.

■ Suspicious deaths of children are routinely signed off in this state by coroners as natural or accidental with no investigation or autopsy. One example: the infant daughter of a drug-abusing mother died after being rolled across the floor like a bowling ball; the coroner listed the case as Sudden Infant Death Syndrome.

■ Children in Georgia are routinely forced to sit in courtrooms crowded with accused felons, waiting for hours to be called to testify in preliminary hearings. One example: A 2-year-old was forced to wait three hours before being called to appear in a preliminary hearing on an alleged case of sexual abuse; when the call finally came, the child was asleep.

■ Overcrowded temporary shelters for abused or neglected children have become dumping grounds for children the state has no other place for and permanent homes for children it can't place. One example: In a shelter serving Atlanta, a mentally retarded 15-year-old, who openly masturbates and who is dying from a fatal disease, sits watching Sesame Street surrounded by toddle[illegible] he has been at the temporary shelter a year.

■ Foster care in Georgia has become a system where children are sometimes more likely to be abused than if they remain with their natural parents, and where those who are raised by the state are often considered damaged goods. One example: A 19-year-old who spent his life in a succession of foster homes had his first-born child taken from him and his parental rights severed, in part because the state believed that growing up in foster care had made the father an unfit parent.

State officials were as affected by the disclosures in the series as the hundreds of readers who called or wrote letters following publication. The comments of Georgia Gov. Joe Frank Harris reflected the sentiments of many:

"The newspaper's articles threw a glaring light on the atrocities visited daily on innocent babies and children," said Gov. Harris. "I feel both a tremendous sadness and a moral outrage that some in our society place such little value on children and that the systems designed and funded to protect them so often do not work."

Both Democratic and Republican state leaders said they expected a package of legislation would be introduced when the General Assembly convenes in January. Grass roots groups of parents already have cropped up to encourage that process.

While some of the problems in Georgia's child welfare system are unique to Georgia, many are not. We encourage you to take a close look at one state's failures, some of its successes and its search for solutions. "Suffer the Children" makes it clear child protection today is too often an illusion. Something must be done to make it a reality.

The Editors

Contents

A Home Is No Refuge For Abused Children 1
One Woman's Fight for Kids 11
Emergency Shelter Is Bursting at the Seams 16
Longing for Home, Longing for Family 22
Children Often Wait 'Their Turn' for Real Home 30
Molestation Trial Pits 6-Year-Old, Stepfather 34
Abused Children: No Voice, No Vote, Little Hope 44
Follow-up Articles, Editorials, Letters 49

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A Home Is No Refuge For Abused Youngsters

By Jane O. Hansen
Staff Writer

On a dark fall night last October, Johnny Aaron Fry of Clayton County took his 2-year-old and 3-year-old sons for a walk and bashed their heads on a paved rural road, killing them.

Fry, who was high on cocaine at the time, pleaded guilty but mentally ill in February to two counts of murder. He is now serving two concurrent life sentences in a Georgia prison.

The case was widely publicized in the days immediately after the children's deaths, as the grisly details unfolded of a father killing his own.

What was never published and what was known only to a select few was that the children were already under the "protection" of the state; that the family had been the subject of five referrals to the county Department of Family and Children Services in the previous eight months; that there had been reports of cigarette burns, a beating that had left marks on one of the boys, and an incident in which the father had threatened one of his children with a butcher knife.

The case is not unique. Last year 51 Georgia children who were already known to child protective service workers died — almost one a week.

The deaths of those children, outlined in case summaries obtained by The Atlanta Journal-Constitution, underscore a child welfare system that is shrouded in secrecy and structured to fail the children it is intended to protect.

It is a system in which overburdened caseworkers often leave children with violent parents, abused children are sometimes placed in foster homes more dangerous than their own, temporary emergency shelters end up as a child's permanent home, and judges routinely ignore laws designed to protect children in court.

It is a system in which a 7-week-old baby who died after her drug-abusing mother "rolled" her across the floor like a bowling ball was listed by a coroner as a case of sudden infant death syndrome (SIDS) — despite a physician's opinion that child abuse was the cause.

SUFFER THE CHILDREN

PART 1

The deaths of such children, who are already under the protection of the state, represent the ultimate failures of the state's child protective system. But an examination of the cases also points to ways to prevent other child deaths.

A three-month investigation of Georgia's child fatalities revealed that:

- Suspicious deaths of Georgia children are routinely signed off by coroners as natural or accidental with no investigation or autopsy.
- SIDS, a natural affliction that generally strikes healthy babies, was listed with unexplained frequency — more than four times the national rate — as the cause of death among infants on the state's caseload.

Some cases were identified without an autopsy, which experts consider essential to the diagnosis.

- Georgia's elected coroners routinely break the law by failing to call a medical examiner when the cause of a child's death is not immediately apparent.
- No one in Georgia keeps record of how many children were killed by their parents — the No. 1 murderers of children under 5. Georgia is one of 10 states that does not keep statistics on overall deaths caused by child abuse, according to the National Committee for Prevention of Child Abuse.
- Communication — between caseworkers, police officers, judges, prosecutors and coroners — is often as lacking as the recordkeeping when children die.

Between 1979 and 1982, four children in the same Clayton County family died of suspicious causes. After the second child's death, the father told medical examiners he was suspicious of his wife. After the third child's death, the only survivor — an 11-year-old girl — told a child welfare worker she was afraid to stay with her mother. The girl was later found dead in her mother's house of "probable asphyxia" of "undetermined cause." The medical examiners had never heard of the girl's request for help, and the welfare worker never knew of the husband's suspicions.

The case was recently reopened as a possible homicide.

"There is strong evidence that Georgia knows little about how often, why or how people have killed children they're responsible for," said Dr. Michael Durfee, a national expert on child fatalities. "In a small but horrible way, a child may be murdered and nobody bothers to do anything."

State child welfare officials are aware of the problem, but say it is far more complex than child protective services alone can solve. Sometimes, they are discouraged from even trying.

Last summer, when the state child welfare agency took a stab at reviewing the suspicious death of a 2-year-old girl who was mysteriously burned to death, they were advised to stop.

"Our lawyers said we don't want to collect evidence to convict ourselves," said Douglas G. Greenwell, director of Georgia's Division of Family and Children Services.

More Than 39,000 Cases in 1987

In 1987 more than 39,000 cases of abuse or neglect were reported in Georgia — and more than half of those cases were confirmed. The figure represents a 26 percent jump from the year before.

In extreme cases of abuse and neglect, children die — mostly at the hands of their parents and mostly before they reach their first birthday.

A March report by Johns Hopkins University School of Public Health showed that for the first time in two decades, homicides had replaced motor vehicle accidents as the No. 1 cause of injury-related deaths for children under 1 in the United States.

While sexual abuse is perhaps the child abuse issue of the day, "the next issue is that people kill their kids," said Dr. Durfee, a child psychiatrist with the Los Angeles County Department of Health Services and a member of the Presidential Commission on Child and Youth Fatalities.

Georgia child welfare officials say they often don't know a lot about how

ABUSED Continued on **Page 2**

Abused

From Page 1

children on their caseloads died, since they sometimes close cases before autopsies have been conducted or before police have concluded their investigation.

"Unlike other states, Georgia doesn't have a real system for reporting child fatalities," said Jan T. South, a child protective services specialist for the state Department of Human Resources. "Basically because no one has said we need to look at that."

In Georgia, so little attention has been paid to the problem that the best the state has is an informal list of children who died while in their custody or who were at least known to the agency. That figure ignores what is probably a larger group of victims.

"For every child that is known, there are probably a dozen that are not known," said Dr. Joseph L. Burton, medical examiner for five metro Atlanta counties and an expert on child abuse.

Cocaine, Crack Share Blame

The mounting number of child abuse and neglect cases is in part rooted in more aggressive reporting, but some experts believe that the actual incidence of violence against children is also on the rise.

One reason for the growing violence is drugs, experts say, primarily cocaine and its derivative, crack. Of the 51 Georgia protective services death cases last year, close to a third had parents involved in drugs or alcohol, according to the summaries obtained by the newspaper under the Georgia Open Records Act. Nationally, 60 percent of confirmed cases of child abuse and neglect involve drug or alcohol abuse, according to the National Committee for Prevention of Child Abuse.

One difficulty in checking the violence is society's reluctance to interfere with the sanctity of the family — the belief that what goes on in a family's home is no one else's business.

"I think society does not give a great deal of value to children," said Dr. Janine M. Jason, a pediatrician and immunologist at the U.S. Centers for Disease Control who did a national study on child homicides.

In the eyes of many decision-makers, Dr. Durfee said, "babies are not people."

Unfortunately, babies under 1 account for 90 percent of all child abuse homicides, according to the National Council of Juvenile and Family Court Judges.

And the younger the child, the more likely that his murderer was his parent or some other caretaker, says Dr. Durfee.

"If you graph out child abuse homicides, the single most important factor to look at is age," he says. "Babies are more fragile when they're younger, they're a whole lot more trouble, parents are more stressed."

Babies also leave no signs of struggle. As a result, an unknown number of children's deaths are mislabeled, according to the National Committee for Prevention of Child Abuse, which estimates that the 1,200 children killed in 1987 may be closer to 5,000.

"I am sure there are children's deaths that occur in the state of Georgia and elsewhere that are certified as accidents or natural that are actually homicides," said Dr. Burton.

One of the most glaring questions arising from the summaries obtained by the newspaper from the state attorney general involves the frequency with which SIDS is ruled as the cause of death, particularly where there has been a clear history of abuse.

Nationally, SIDS accounts for 13.6 percent of all deaths of babies under 1, according to the National SIDS Foundation in Landover, Md. Yet of the 19 deaths of Georgia infants known to the state last year, 11 — or 58 percent — were listed as SIDS deaths, the summaries show.

"Some of those children may technically be SIDS," said Dr. Burton. "There is a preponderance of them in the lower socio-economic class." Nevertheless, he said, he suspects many deaths are mislabeled. "I think there are many cases signed out as SIDS that aren't SIDS."

The National Committee for Prevention of Child Abuse estimates that [illegible] percent to 10 percent of the 8,000 SIDS deaths that occur across the nation each year are in fact homicides.

State officials agreed that a number of the summaries citing SIDS leave unanswered questions.

"SIDS is often on the death certificate, but if you look at some of the factors, you wonder," said Gerald V. Gouge, chief of the state's Child Protective Services Unit.

Vale Henson, a veteran child protective services caseworker for DeKalb County, had one neglect case in which the baby's weight when she died was 6 pounds — 2 pounds less than her weight at birth. Doctors tagged the death a natural SIDS.

"The baby died of starvation," Ms. Henson said.

The diagnosis may be overused in Georgia because coroners often label a death as SIDS without an autopsy, an essential element to making the diagnosis, medical experts say.

A review of Georgia death certificates shows that of 112 SIDS deaths outside Atlanta last year, 44 were diagnosed without autopsy.

At the root of Georgia's problem, say forensic pathologists and some child welfare experts, is this state's reliance on a system of elected coroners who have little medical training.

"Let's face it," said Dr. Joseph H. Davis, Dade County medical examiner in Miami. "Georgia is the last outpost. It's got a long way to go before it cleans up its act."

The subtle differences between SIDS and suffocation are difficult to de-

DWIGHT ROSS JR./STAFF

Brandon Miles Frix, 2, and Jarratt Aaron Frix, 3, were murdered by their father on a rural road in Forsyth County last October. He was high on cocaine at the time.

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tect even with an autopsy, forensic experts say. They're nearly impossible without. Small children also can be strangled or drowned in bathtubs with a fair amount of ease and little detection.

In Los Angeles, where a sophisticated team of professionals investigates all suspicious child deaths, bathtub drownings are the cause of death most frequently moved from the accident to homicide category after the review.

"A 2-year-old who drowns in the bathtub — that's a homicide until proven otherwise," said Dr. Davis of Miami.

That was not the case for a 4-year-old Georgia girl who died last year. According to the summary of her case, an emergency room physician who treated her for mouth injuries reported to the child welfare agency that he suspected she was being abused. He said the mother's behavior was not normal, and he described her as "overly critical" and "very rough" with the child.

By the time a child welfare worker got in touch with the family, the little girl was dead. "The child drowned in a bathtub," the summary says. The agency "had no further involvement after referring relatives for therapy to assist them with their grief."

Team Approach to Probing Deaths

In recognition of the growing problem of child fatalities, 32 states have established child fatality review teams to look at all suspicious deaths. Georgia is not one of them.

The Los Angeles team, which Dr. Durfee helped to form in 1978, reviews the deaths of all children under 10 where one or more of a number of factors are found, including drugs, bathtub drowning, asphyxia, SIDS over 7 months, drugs or burns.

Included on the team are representatives from the medical examiner's office, police and sheriff's departments, district attorney's office, the Department of Children's Services and the Department of Health Services.

No one in Georgia keeps record of how many children were killed by their parents — the No. 1 murderers of children under 5. Georgia is one of 10 states that does not keep statistics on overall deaths caused by child abuse.

In 1986, the team reviewed 203 suspicious deaths. Of those, 52 were designated as child abuse homicides.

"We learn best from those situations where we have clearly failed," said Dr. Richard D. Krugman, director of the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, located in Denver. "Unless you bring all these people into one room to discuss what they know about a given child's death and the family, you're not going to make progress in understanding what's going on."

Such information automatically leads to improvements in the child welfare system, including more convictions of people who previously might have gotten away with murder.

After creation of a fatality review team, Oregon's conviction rate in child abuse homicides rose from 50 percent in 1985 to 90 percent in 1987.

"As the system ties itself together, the first thing you get is more criminal action," Dr. Durfee said. Coroners do a better evaluation, surviving siblings are protected, and potential child abusers are identified, he said.

Often, child homicide occurs when a parent under stress, with limited financial or emotional resources, lashes out unintentionally at a child.

"It's something that is avoidable if someone was there to help," Dr. Durfee said.

The notion of a parent killing his child — particularly a helpless infant — is a difficult one for the public to grasp. Most parents at some point experience the anger a child can trigger, sometimes scaring themselves with the force they use to spank their child. That common experience is one reason why the offense of child abuse may go undetected or unpunished until a child is dead.

But there is a line that is crossed, fine as it may be, that distinguishes between occasional uncontrolled anger and anger that kills.

Rare Footage of Child Abuse

Recently, rare footage of child abuse in action captured the nation's attention after a Tennessee couple secretly videotaped their baby sitter hitting their 6-month-old baby boy.

The parents had become suspicious of the woman after their 3-year-old daughter told them the sitter was hitting the infant. In a dramatic display of anger, the tape shows the 27-year-old sitter whacking the baby on the side of the head as she sits feeding her. The child was not seriously injured.

"It's a striking case in the sense that when you see the way this particular baby sitter slammed the head twice of this infant, the force is staggering," said Dr. Krugman, during a recent child abuse conference in Atlanta. "It's difficult to watch."

What's even more striking, he said, is that the baby had no brain injuries.

"If a blow of that nature doesn't cause injury, imagine what kind of a blow does," Dr. Krugman said. "It is substantial. The kinds of forces that are brought to bear on children by enraged adults is unbelievable."

How Journal-Constitution Carried Out Investigation

More than six months ago, The Atlanta Journal-Constitution began efforts to find out what had happened to 51 child abuse or neglect victims whose plight was known to Georgia social workers at the time of their deaths last year.

The Journal-Constitution filed a request for the files under the Georgia Open Records Act, suggesting that names and specific identifiers be removed to avoid any invasion of privacy.

State Attorney General Michael J. Bowers denied the request, saying the records were protected by confidentiality laws, even though the children those laws were designed to protect were dead.

Rather than turn over actual records of the cases, many of which are now closed, Mr. Bowers instructed Assistant Attorney General Carol Cosgrove to help the state Division of Family and Children Services prepare summaries of the files.

Forty-two summaries were provided. They are sketchy and often prompt more questions than they answer — such as whether an investigation into the death was ever conducted, whether anyone was ever arrested, whether an autopsy was done, and what efforts were made to protect siblings still at home.

The New Homeless: Babies Addicted to Drugs at Birth

By Jane O. Hansen
Staff Writer

At Grady Memorial Hospital, a baby girl the size of a human hand lies in a glass bubble trying to stay alive. The baby's mother, a 22-year-old cocaine addict, shot up only hours before her birth, causing the placenta to rip free of the woman's body and sending the mother into a rapid, frantic labor. The baby was born seven weeks before she should have been.

Because of the cocaine in her veins, she was born in shock with a profoundly low heart rate. A plastic bag lies on her abdomen, collecting her waste directly from the hole left in her intestine.

She still has periodic seizures from too little blood flow to her brain, making her a strong candidate for cerebral palsy and mental retardation. Her immature lungs require an oxygen hood, and her tiny body jerks to a rapid rhythm as she labors to breathe.

"This baby is going to be a disaster," said Dr. William R. Sexson, a neonatologist and medical director of Grady's special care nurseries. "She will never be a functioning member of society."

Babies like these are about to crush the state's already overwhelmed public hospital and child welfare systems. They are a new and sickly population of homeless children, left in the wake of skyrocketing cocaine abuse and the related specter of AIDS. At Grady alone, a staggering 200 babies a month are born who show signs of drug addiction, primarily to cocaine.

Increasingly across the country, these babies are being abandoned by their parents to live as hospital "boarder babies."

"These are likely to be children forever in the care of the state," said Dr. Deborah A. Daro, director of research for the National Committee for Prevention of Child Abuse. "We are not finding a lot of homes that will take these children in."

Nationally, as many as 375,000 babies — 1 in 10 — are born each year to drug- or alcohol-abusing parents, according to the committee.

Experts say that not only are babies abused before they're born by pregnant women on drugs, but they're also more likely to be abused after they're born if they're sent home with drug-using parents.

Heavy users of cocaine, and its highly addictive derivative crack, are incapable of caring about much else, including the welfare of a child. In one recent case, a Stamford, Conn., woman arranged on several occasions for her 10-year-old daughter to be raped by a 48-year-old man in exchange for money to buy crack.

Besides fostering neglect, crack has unleashed a disturbing wave of violence against children, child abuse experts say. In New York City, 11 percent of child abuse and neglect deaths in 1985 were tied to parental drug use. By 1987, as crack use became widespread, that figure had jumped to 73 percent.

Murder 'Much More Likely'

Cocaine babies are more likely to be premature, suffer from neurological disorders, have cardiac malformations and experience respiratory difficulties. At Grady, 10 percent of the cocaine babies born prematurely become blind, 40 percent have the equivalent of a stroke, said Dr. Sexson. Many will develop dyslexia.

Such problems are stressful enough for a normally resourceful parent; they're overwhelming for one damaged by drugs.

"The drug babies are much more likely to be murdered because they're harder to manage and the families are much less managable," said Dr. Michael Durfee, a Los Angeles child psychiatrist and national expert on child abuse homicides.

Phyllis W. Miller, Grady's chief pediatric social worker, said that in 1979 the hospital referred one baby of an addicted mother to the local protective services worker; last year, the number was 212.

Increasingly child abuse experts are recognizing that parents' drug addiction, particularly to cocaine or crack or PCP, could be a prescription for violent abuse or neglect of their children.

Yet Georgia has no policy linking drugs and abuse, and the state child welfare department has no requirement that hospitals report babies born to drug-abusing parents, although Grady now does so.

"Maybe the state just needs to make a policy about children who are born addicted that says we consider this abuse or neglect," said Gerald V. Gouge, chief of the child protective services unit for the state Division of Family and Children Services in the Department of Human Resources.

Georgia is not alone in its lack of a policy. Only a few states, including Oklahoma and Utah, have laws requiring that parental drug abuse at least trigger an investigation by child protective services to determine whether or not a child is safe at home.

Besides the risk of abuse and neglect, babies born to drug-abusing mothers are also at risk of contracting the virus that causes AIDS. Georgia now ranks 11th nationally in its number of AIDS-infected children, according to the Department of Human Resources.

A study sponsored by the national Centers for Disease Control due for release at this week's international AIDS conference in Montreal: 1.8 of every 1,000 babies born in Georgia are now testing positive to the AIDS virus.

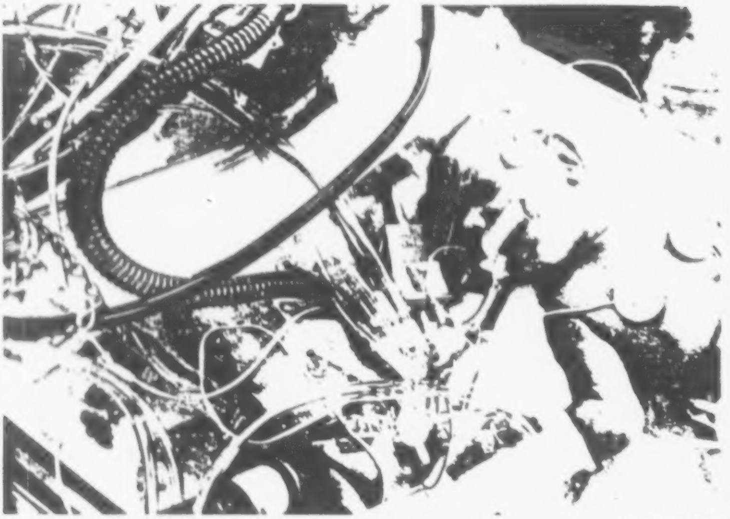
The majority are born to drug-addicted parents whose needle sharing led to their own AIDS infection, said Dr. Joseph A. Wilber, medical director of the AIDS programs for the Department of Human Resources.

Georgia was one of about 20 states that participated in the CDC study by testing all babies born from September of last year through February of this year. The study's results mean that this year alone, about 184 babies will be born in Georgia who test positive. Roughly a third will probably die from AIDS within two years, said Dr. Wilber.

National estimates are that by 1991 at least 20,000 children will be infected by the AIDS virus.

The implications are huge for a state welfare system that is already overwhelmed. Without a plan for the future, experts say drug-damaged and AIDS-infected babies will live out their lives in overtaxed public hospitals that are already collapsing under the weight of other medical and social problems.

These children's futures will be as grim as Dr. Sexson's 3-week-old patient at Grady. In the baby's sterilized, incubated world, even the little bear propped next to her head must be wrapped in plastic to protect her from



WALTER STRICKLIN Staff

A 1-month-old boy, addicted to cocaine at birth, breathes with the help of a ventilator in an incubator at Grady Memorial Hospital. He was born eight to 10 weeks premature.

germs There is a tube through her belly and another needle in her hand Yet as fragile as she appears this baby will probably live "Most do," Dr Sexson says And like most she'll probably go home

After she was born her mother promised the hospital social worker that she was going to get off drugs "Both the mother and father are already shooting up again," Dr Sexson said

'He's Like a Stroke Patient'

On a window in Grady's intensive care nursery is a drawing of a child holding a bunch of flowers "I have AIDS, please hug me," the poster says

It's a sign of how things have changed since Dr Barbara Bruner first walked Grady's hallways 30 years ago tending to sick children In those days there were no babies dying of AIDS Babies born addicted to drugs were rare And while children were beaten burned and occasionally raped by their parents they were the exception

Last year the hospital treated about 1,200 abused or neglected children double what the hospital saw five years ago

"And it's not going to get better," Dr Bruner the director of Grady's pediatric emergency clinic recently warned the state Board of Human Resources "It's going to get worse"

On the ninth floor, a 14-month-old baby boy has been living in a steel crib Dressed one recent day in a diaper and striped T-shirt he lay alone in a room surrounded by empty cribs

Three months ago, he was brought into the emergency room in convulsions His mother had allegedly beaten him to the point of fracturing his skull and the baby had to be whisked into emergency surgery to evacuate the blood clots caused by his brain hemorrhage

"He's like a stroke patient," Dr Bruner said as she petted the curly-headed boy's stomach "He's paralyzed on his left side and he's got very stiff extremeties Plus he's brain damaged I think he doesn't see"

His future is unclear Criminal charges are pending against his mother but there were no witnesses to the beating making a conviction unlikely And she wants her child back The county Department of Family and Children Services does not want to return the baby to a mother social workers consider unfit yet they have had difficulty finding a foster family willing to take him just temporarily Recently they found one

A Hospital for a Home

Child welfare workers know a good thing when they see it Too often Grady officials say, the county drags its feet in placing babies such as these knowing they are at least safe in the hospital It is a trend Dr Bruner finds increasingly frustrating

Recently a baby with no medical problems lived at Grady more than a month after she was born Her mother was psychotic, and alternated between sleeping under a viaduct near the hospital and in Grady's lobby

Finally Dr Bruner instructed her staff to call the Fulton County Department of Family and Children Services and tell officials the hospital was setting up a small bassinet under the viaduct so the mother could take the child home

"Maybe that will be an incentive to do something about this child," she

ADDICTED Continued on **Page 6**

Addicted

From Page 5

said. "The point is, we're stuck with the child. We have no legal responsibility for the child, except that we have no place that we would personally dismiss it to."

As many as eight babies and children live at Grady at any one time because there is no other place for them. Twice that number remain in the hospital for medical treatment with no contact by their parents, and the number will continue to grow as long as crack and cocaine remain a problem, experts say.

With cocaine, the greatest threat to unborn babies is prematurity, says Dr. Sexson, which creates a host of medical problems. Yet sophisticated technology has rendered survival of the fittest a thing of the past, and today many of these babies are kept alive.

"When I was a medical student, we didn't even fill out birth certificates on babies that weighed under 1,000 grams (2.2 pounds)," Dr. Bruner said, leaning over an incubator where a baby that looked more like a fetus lay with needles and tubes in her belly, arms, feet, and mouth. "They were abortions."

The costs to society of keeping these children alive are enormous: $2,500 a day in a private Georgia hospital for a baby on a ventilator, $1,200 for care at Grady's intensive care nursery and future unknown costs for a growing number of babies whose disabilities will be permanent.

Foster Homes in Short Supply

For one baby girl who was recently born at Grady with AIDS, the only person who offered to give her a home was a single man who also had AIDS. But his doctor wouldn't let him do it, arguing the baby's illness might complicate his own.

When the baby was 9 months old, her mother — a drug addict — came to the hospital and took her home. But a few days later, family members returned her to the hospital's emergency room. At 10 months, the baby girl died alone at Grady.

Such stories prompted Douglas G. Greenwell, director of the state Division of Family and Children Services, to recently blanket the state with an appeal for more foster parents willing to take AIDS babies.

The lack of foster families for such babies has forced some caseworkers to return children to what they know are dangerous situations, Dr. Bruner said.

Her voice becomes particularly high-pitched as she talks about a baby who on this particular day was in intensive care struggling to survive second degree burns he allegedly got at the hands of his mother.

He had been brought to Grady a month earlier with a broken leg when he was only a month old. The mother admitted she had broken her baby's leg. Considering that confession a sign of good faith, caseworkers with the Cobb County Department of Family and Children Services sent the baby home with her.

Because Grady staff continued to protest, the county agreed to do a home visit and provide follow-up services. Almost four weeks to the day, the baby was brought back to Grady, this time with severe burns to his legs, spine and scrotum. He had been dipped in scalding water.

The county has since filed for custody of both the baby and his 2-year-old sibling, and criminal charges have been filed against the woman.

"You don't burn a baby like that by accident," said Dr. Bruner. "And we don't send children home expecting them to die. We send them home expecting them to live."

NICK ARROYO/Staff

Dr. Barbara Bruner hugs a small patient during her rounds at Grady. Few abused children were treated at the hospital 30 years ago. That's changed, and 'it's going to get worse,' she says.

Getting Away With Murder

'Archaic' System of Investigating Deaths May Pave Way For Parents to Kill Their Children

By Jane O. Hansen
Staff Writer

In Georgia, you can get away with murder if your victim is your child.

Crass as it may sound, if you strangle or smother your infant with a pillow, tell your local coroner the child has recently had a cold, and act distraught, coroners in many Georgia counties will bypass an autopsy and mark the death certificate as pneumonia or sudden infant death syndrome, medical experts say.

"Georgia still has one of the most archaic death investigation systems in the nation," said Dr. Joseph L. Burton, medical examiner of five metropolitan Atlanta counties and a child abuse expert.

Revamping the state's coroner system would be a first step toward understanding why such children die in Georgia and perhaps preventing some of those deaths, say some child welfare experts and medical examiners. Specifically, they say, the state's elected coroners should be replaced with a medical examiner's system of trained forensic pathologists.

"If we had a really good medical examiner's system in this state, we could probably tell something different about these questionable cases," said Gerald V. Gouge, chief of the state Child Protective Services Unit. "It's always surprised me that we don't get more deaths that are caused by abuse or neglect."

Outside metro Atlanta, the majority of Georgia's counties rely on elected coroners to determine whether the cause of death is natural, an accident, a homicide, suicide or undetermined. To be a coroner, candidates need only have a high school education, be at least 25 years old and have no felony convictions.

"There have been service station attendants, people who are legally blind, people who will not touch a dead body who have been coroners in Georgia," said Dr. Burton, one of a handful of the state's forensic pathologists, specialists trained in the legal and scientific investigation of deaths. "Yet these people technically have the power to put on that death certificate a cause of death and a manner of death. And they have the power to ask that an autopsy get done or not get done."

According to Dr. Burton, the coroner of one central Georgia county signed off 95 percent of all deaths as heart attacks. The rate is generally 40 percent to 45 percent. In another county, the white coroner routinely attributed the deaths of black babies to neglect, he said.

> 'There have been service station attendants, people who are legally blind, people who will not touch a dead body who have been coroners in Georgia.'
>
> **— Dr. Joseph L. Burton**
> **Forensic pathologist**

In the deaths of most children, it is imperative to conduct an autopsy to determine the cause, experts say. Unlike adults, most children don't die of disease or readily apparent natural causes. Yet according to records kept by the Department of Human Resources, of the 1,601 Georgia children under 7 who died in 1987, only 37 percent were autopsied.

A report last year by the statewide Council on Maternal and Infant Health found that "a majority of postneonatal deaths outside urban areas in our state are not autopsied. There is no autopsy system, nor rules and regulations for the performance of death scene investigations, and no required qualifications for those performing autopsies."

One reason coroners skip autopsies is to spare the family. "The death of a child is very traumatic to the family," Dr. Burton said. "The people involved with the investigation — whether law enforcement or coroners — tend to try to find an excuse not to do the autopsy."

Another reason is politics. Small-town coroners are susceptible to the wishes of their constituents. According to Dr. Burton, at a family's request state senators and "people higher than that" have often asked him to waive an autopsy.

"A great number of the coroners own funeral homes locally," Dr. Burton said. "If you're in a small Georgia town, and you own the funeral home, and you're the coroner and you've buried everybody in that county for 20 or 30 years, politics are thick."

That type of political pressure, he said, could be responsible for an unknown number of mislabeled children's deaths.

In some cases, Georgia children whose deaths are blamed on natural or accidental causes in fact may have been murdered.

"I think the biggest problem is that children are so easily killed without leaving any sign," said Dr. J. Byron Dawson, director of the State Crime Lab in Atlanta. "Just cover their mouths with your hand, put a plastic bag over their heads, no problem."

Children can be easily strangled, suffocated, poisoned or even drowned in a bathtub with little or no detection, say forensic pathologists. Even an autopsy may not reveal the cause of death, making death scene investigations particularly crucial to any questionable death of a child.

"You can have the same autopsy findings, but based on the circumstances, one can be labeled natural and another an accident," said Dr. Joseph H. Davis, Dade County medical examiner in Miami.

Illinois and Minnesota are among the states that have recently enacted laws outlining protocols for investigating all questionable children's deaths, including a thorough death scene investigation and autopsy.

Under the Georgia Post-Mortem Act, a coroner must contact his local medical examiner whenever the cause of a death is in question. It is then up to the medical examiner — usually a local physician with little training in pathology — to decide whether an autopsy is warranted.

But in Georgia, the question of a child's death often stops with the coroner.

In cases where coroners don't seek the advice of a physician, they clearly "are not abiding by the law," Dr. Burton said. "Seventy-five percent don't abide by the letter of the law."

Thomas L. King, president of the Georgia Coroners Association and coroner for Columbia County, disagreed. Mr. King, who operates a funeral home, said he did not know why so few children in Georgia were autopsied. But he

MURDER Continued on **Page 8**

Murder

From Page 7

said. "Most of us do what we're supposed to do. I'd say 95 percent of the coroners do what they're sworn to do. But you do have some bad apples. And it makes a name for the rest of us."

He said the deaths of children increasingly are being recognized as tricky situations for coroners. Last year, half of the coroners' 16 hours of required training was devoted to the detection of child abuse homicides, according to Mr. King.

A major stumbling block is a shortage of pathologists willing to do autopsies, he said. Nationally, there are about 500 forensic pathologists such as Dr. Burton, and in Georgia there are fewer than 10.

The state pays only $450 per autopsy for a coroner's case, and it is not worth most pathologists' time, said Mr. King. As a result, most counties refer autopsies to the State Crime Lab, which currently has no forensic pathologist. Among those who perform the procedure are a chemist — Dr. Dawson — and a biochemist.

"Georgia is the only state in the country and the only jurisdiction in the Western world that allows non-physicians to do autopsies," said Dr. William R. Anderson, an associate county medical examiner in Naples, Fla., who formerly worked as a pathologist in Georgia.

Dr. Dawson agrees that the Georgia coroners system may be in need of a statewide facelift.

"You're probably looking at the vestiges of a system that's about to change," he said. "Pay attention to what's going on in Georgia in the next six months. We're going to embark on a new era of death investigations in Georgia, which I think will eventually wind up with regional medical examiners scattered around the state. It will be a tremendously slow, expensive undertaking. But we've got to change [because of] the sheer volume, and it's time this system moved forward."

According to Dr. Dawson, these regional medical examiners would all be trained in pathology and capable of doing their own autopsies. Such a system is already in place in most states.

The coroners may be reticent to embrace the change, however, and they are not without political influence in the Legislature. "I would have a problem with the regional system," Mr. King recently said. "Because of the expense of it. It would cost the taxpayers."

Can The Law Protect A Fetus From A Drug-Abusing Mother?

By Jane O. Hansen
Staff Writer

Last month, a Rockford, Ill., woman was charged with involuntary manslaughter after her infant daughter died as a result of the woman's cocaine addiction during pregnancy. Prosecutors called it the first case of its kind in Illinois.

In Florida, a woman was charged last December with child abuse after her baby was born addicted to cocaine. According to officials, the felony case, which comes to trial this week, was the first of its kind in Florida.

A Washington, D.C., judge sentenced a 30-year-old woman last September after she was convicted for check forgery. The offense is usually punished with probation — but the judge sentenced the woman to jail for the duration of her pregnancy.

"She's apparently an addictive personality, and I'll be damned if I'm going to have a baby born that way," said Superior Court Judge Peter H. Wolf, according to trial transcripts.

In courtrooms across the country, as the phenomenon of drug-abusing pregnant women grows, prosecutors are holding these women to a higher standard of maternal care than ever before. But some legal scholars see a collision ahead.

Already in child abuse cases, judges must grapple with conflicts that pit the rights of parents against the rights of their children. As judges seek to protect the unborn, they are sailing into uncharted seas, where the rights of a fetus can run smack up against the woman's right, at least during much of her pregnancy, to abort that fetus.

"The controversy is the same you see in abortion cases," said Dr. Deborah A. Daro, director of research for the National Committee for Prevention of Child Abuse. "It's a matter of when life begins."

Whether the definition of child abuse should extend to an unborn fetus is as tricky and unresolved as the issue of abortion. Experts pose this question: What if the woman jailed while pregnant had decided to have an abortion as a means for getting out of jail? Does the law permit her, in effect, to kill her fetus yet prohibit her from abusing it?

"That's a really complicated and difficult issue," says Patricia A. Toth, director of the National Center for the Prosecution of Child Abuse. "I can see some differentiation between the mother who has chosen to carry the child to term and intends to have the child born. Just as a matter of moral obligation, it seems to me, there is some duty there to not needlessly endanger the child. Whether or not that means there should be criminal penalties for failure to do that is complicated."

Abortion opponents say the issue offers support for their argument that a fetus is a live human being. Even child welfare experts acknowledge that once the courts get into the business of protecting fetuses, they may have difficulty defending abortion.

"If you recognize their rights as a fetus for the purpose of protecting them under child protection laws, then you are in fact recognizing their right to life," said Dr. Daro.

Besides the legal dilemma that a woman's right to abortion poses, there's a real question of how far government should go in protecting a fetus from the harmful behavior of its mother. According to a recent Gallup Poll, 48 percent of the American public believes that pregnant women who smoke or drink should be held liable for harm to the fetus.

"Where do you draw the line?" said Robert M. Horowitz, associate director of the American Bar Association's National Legal Resource Center for Child Advocacy and Protection. "Cocaine is bad, but so is drinking three glasses of wine, or not getting enough rest or abusing your body with the wrong foods. If she doesn't stop, what do you do?"

Staff writer Tracy Thompson contributed to this article.

Confidentiality Laws Throw Cloak of Secrecy Over Abuse

By Jane O. Hansen
Staff Writer

'Confidentiality laws were enacted to protect children from exploitation. But they have taken on a life of their own.'

— Richard L. McDevitt, Georgia Alliance for Children

Among the Georgia children who died last year while under the state's protection were a little girl who was raped and found floating dead in a pond, a 14-month-old baby girl found dead on her parents' railer floor from an apparent bathtub drowning, and a 13-month-old baby girl who was placed in a steaming hot tub of water after she removed her own diaper and soiled the bed sheets.

All three children were well-known to the county child welfare departments. But they died in relative anonymity.

Georgia's child welfare system is shielded by a cloak of confidentiality that makes it nearly impossible for the public to scrutinize its activities. When an abused or neglected child dies in Georgia, almost no one is held accountable.

Georgia child welfare workers say the assurance of confidentiality is critical in convincing citizens to report abuse. Besides, they say, state and federal law clearly dictates that records involving children must remain private. Not only could they be sued or prosecuted if they broke that law, but they could lose their jobs, they say.

Yet a computer search of Georgia Supreme Court decisions, federal appellate cases and U.S. Supreme Court decisions turned up no successful lawsuit or criminal prosecution of a caseworker for violating confidentiality statutes in Georgia — or anywhere else in the country.

Furthermore, no child welfare worker in Georgia has ever been fired strictly for a breach in confidentiality as far as state officials can determine, said Joyce Goldberg, a spokeswoman for the Department of Human Resources.

"Confidentiality is a smoke screen that hides the abuses and failures of the system," said Richard L. McDevitt, president of he Georgia Alliance for Children. "Confidentiality laws were enacted to protect children from exploitation. But they have taken on a life of their own."

In some Georgia counties, child welfare officials are so loyal to confidentiality codes that they refuse to share information with local law enforcement officers. District Attorney Robert E. Keller of Clayton County said he finally was forced to sit down with the local child welfare director and talk about the fact that they were on the same side.

W. A. BRIDGES/Staff

Sheriff Wesley Walraven said child abuse 'needs to be . . . overt before government interferes.'

Many caseworkers believe they would be better off if they could tell their side of the story. New Jersey child welfare officials recently asked the federal government to loosen up confidentiality regulations so they could more effectively defend their decisions.

"We end up looking like such fools because we can't defend ourselves," said Carol Campbell, director of the Forsyth County Department of Family and Children Services.

It was Ms. Campbell's workers who investigated several child abuse complaints involving Charles Aaron Frix, who pleaded guilty to murdering his two sons, 2 and 3, last October.

Initially, Ms. Campbell declined to discuss the case because of confidentiality restrictions. But a document obtained by The Atlanta Journal-Constitution shows that her department had known of the family's problems for at least eight months.

Among the complaints filed was a report that the 2-year-old had cigarette burns on his body. Frix's 7-year-old daughter had told caseworkers that her father had threatened her with a butcher knife.

"The father, in front of the caseworker, stuck a pocketknife in the coffee table to show what the 7-year-old had described," the report says. "Caseworker explained that even this would frighten a small child."

Despite visits to the Frix home, Ms. Campbell said, the caseworkers were unable to substantiate any of the allegations. If they had had the facts, she said, they never would have left the children at home.

"You cannot go to court on your gut-level feeling," she said. "If you cannot see the cigarette burns, and there are no marks on the child, you just don't have a case."

Sheriff Wesley Walraven of Forsyth County, who first charged Frix with murdering his sons, also defended the department's handling of the case.

"I probably would have done the same thing they did," he said. "[The abuse of a child] needs to be out there overt before government interferes in a family's activities."

Ultimately, he said, the decision to remove a child is a judgment call.

It's those critical judgment calls — and the caliber of the people who make them — that critics say provide a compelling reason to crack open the system. "Sunlight is the best disinfectant," said Nat Hentoff, a writer for The Village Voice who has written extensively about New York's child welfare system.

Without a complete account of what happened in Forsyth County, there is no way of knowing whether Ms. Campbell's assessment of her agency's actions is an accurate one, said state Sen. Pierre Howard, chairman of the Senate Human Resources Committee. And the state's own internal review is not enough, he added.

"The whole purpose of [confidentiality] is to protect the children," said Mr. Howard, "and if the rules work against that, then the rules need to be changed. It's obvious that this is an area that needs to be examined."

Ms. Campbell agrees that a more open system might benefit from public concern.

"I think it would muster community support if they knew what our caseworkers are up against," she said.

The Beginning: An Unloved Child In N.Y. Slum Set Reforms in Motion

By Tracy Thompson
And Jane O. Hansen
Staff Writers

A century ago, there was a society to prevent cruelty to animals. Children weren't so lucky.

In December 1873, while making rounds in a New York City tenement, nurse Etta Wheeler heard from neighbors of a child in the building who was being beaten daily by her foster parents. She talked her way into the apartment and caught a glimpse of a 9-year-old girl named Mary Ellen.

"From a pan set upon a low stool she stood washing dishes, struggling with a frying pan about as heavy as herself," Mrs. Wheeler wrote later. The child appeared barefoot, ill-clothed and half-starved. "Across the table lay a brutal whip of twisted leather strands, and the child's meager arms and legs bore many marks of its use. But the saddest part of her story was written on her face in its look of suppression and misery, the face of a child unloved."

During the next few months, Mrs. Wheeler reported Mary Ellen's plight to police and to charities, who did nothing. In desperation, she turned to Henry Bergh, president of the Society for the Prevention of Cruelty to Animals.

Mr. Bergh got a judge's permission to intervene on "humanitarian" grounds. "I saw a child brought in, carried in a horse blanket, at the sight of which men wept aloud," wrote Jacob Riis, a newspaper writer who was in the courtroom that day. Mary Ellen's body was bruised and her face had a large gash on the left side where her foster mother had cut her with scissors the day before.

Using laws that banned cruelty to animals, the judge ordered Mary Ellen taken away from her foster mother — the first recorded case of a court intervening to protect a child from abuse. Nine years after the creation of the American Society for the Prevention of Cruelty to Animals, New York City established the nation's first child protective agency.

"That was the beginning of seeing [child abuse] as a civil issue as well as a criminal issue," says Paul Smith, director of research at the Children's Defense Fund in Washington. "You can think of what happened in child abuse as the very first victims' rights movement."

Special

Mary Ellen, the abused child whose case spurred passage of child protection laws a century ago, as she appeared at the time of her rescue (left) and a year later.

Many more reforms followed, such as the creation of juvenile courts, the passage of child labor laws and identification in 1962 of "the battered child syndrome," which led to requirements in all 50 states that doctors report abuse cases to police.

While many child abuse cases still end badly, the case of little Mary Ellen at least gave children a better chance at being rescued from miserable circumstances. Mary Ellen's story, in fact, had a happy ending.

Within a year of her rescue, Mary Ellen was sent to live with Mrs. Wheeler's family in upstate New York. Nourished and loved, she was "fast becoming a normal child," Mrs. Wheeler wrote.

"When 24 she was married to a worthy man and has proved a good homemaker and a devoted wife and mother," the nurse wrote years later. "If the memory of her earliest years is sad, there is this comfort — that the cry of her wrongs awoke the world to the need of organized relief for neglected and abused children."

One Woman's Fight for Kids — 'Am I a Miracle Worker?'

By Jane O. Hansen
Staff Writer

SUFFER THE CHILDREN

PART 2

On a typical day last fall, Vale Henson was looking for a dead baby.

Methodically, she opened every drawer in the disheveled room of a north Atlanta motel where she had agreed to meet V., the mother. Then she checked the bathroom and wastebasket.

For one awful moment, the DeKalb County social worker thought the week-old infant lay under a heap of bedclothes. "I'm calling the police," she said, spotting what looked like a bedful of dried blood stains at Motel 1 in Chamblee. The stains turned out to be chocolate, the remnants of doughnuts.

Still, Ms. Henson worries that V. is crazy and her children unsafe. Recently V.'s mother said her 26-year-old daughter poured gasoline throughout her apartment and threatened to burn up herself and her other two babies — a 1-year-old son and a 2-year-old daughter. Ms. Henson thinks V. may be sexually abusing the 2-year-old, and she wants to get all three children into a safer home, at least until V. gets the help she needs.

But she has little chance of doing that. Once before she took V.'s daughter away from her and put her in foster care. And once before the courts gave the child back. Even if Ms. Henson did succeed in getting V.'s children removed from their home, where would she put them? There is a critical shortage of foster care homes in Georgia, and those homes that do exist are often "the pits," in Ms. Henson's words.

"What am I going to do?" Ms. Henson says. "Am I a miracle worker?"

The story of V. is the reflection of a child welfare system in Georgia that is failing to protect thousands of children as it is choked by mounting reports of abuse and too few resources to deal with them. From overtaxed and underpaid workers to a fragmented court system that often emphasizes parents' rights at the expense of children's, Georgia's child welfare system is traveling down a collision course, experts say.

"I've been here 31 years, and it's as bad or worse than I have ever seen," said Shirley Trussell, director of the DeKalb County Department of Family and Children Services. "Either we procure the resources to do the job or say to the public, 'We are no longer able to do this job.'"

In 1987, more than 39,000 child abuse and neglect reports were filed with the state — a 26 percent jump over the previous year's statistics that surprised even state officials.

"The cases we're coming across now are totally different than the cases we came across 10 years ago," said Jan T. South, a child protective services specialist for the state Department of Human Resources. "They're serious cases — children who have been sexually abused over long periods of time, children who are severely beaten."

At the same time, Georgia officials are finding it ever more difficult to attract and retain child welfare workers in an increasingly hazardous job that, for many, pays less than school teacher wages. The average caseload has grown to 32 families per worker, compared with the 17 recommended by national organizations. Ms. Henson's caseload normally tops 40, and some urban caseworkers deal with as many as 90 families at a time.

"It's not right for children's whole lives to be determined by a social worker who spends one hour a month with them," said Ms. Trussell. "And at best, that's what most of our kids get."

Behind the statistics are the individual children, whose suffering is often compounded by the system's failure.

'The Real World'

It's Tuesday morning and Vale Henson (her first name is pronounced like valet) is getting ready to leave her cocoon of an office and enter what she calls "the real world."

At 35, Ms. Henson is a tall, healthy-looking woman with a round face, turned-up nose and a raucous laugh.

When she first got into child protective services, she worked as an intake worker for Fulton County, investigating cases of abuse and neglect as soon as they were reported. She compares the job to that of an emergency room triage nurse who must pick which patients need treatment first.

"I would come into work and have to choose between a 2-year-old with gonorrhea at Grady, twin babies left home alone or a family of five with no food. How do you make a choice?" she says, laughing at the absurdity. "I don't know."

Today, she holds the job of "ongoing protective services worker" for DeKalb County, trying to help those families that intake workers have confirmed as probable child abuse or neglect cases.

To her "clients," she can be mother and friend, cop and jailer, loved and hated by the children, who see her both as the heroine who rescues them from abusive adults and the villain who takes them away from the only people they know and love.

On this particular day, one of Ms. Henson's first stops is D.J.'s house, an apartment in a drug-infested Atlanta housing project where rat holes line sidewalks and a large portion of the red-brick apartments are boarded up.

As she enters the apartment, 6-year-old Michael is standing on the stairs scrubbing the walls. Wearing Hawaiian shorts and a blue T-shirt, the little boy is carrying around a bucket of Pine-Sol, soaping everything in sight. He's cleaning at the direction of his mother, D.J., who's reeling from drink or drugs or both. As he begins to wash a wooden coffee table, D.J. yells at him.

"Give me that rag," she says, her eyes drooping, her body swaying. "You don't put all that soap on the table. You see? He's a disobedient child. You can tell that by looking at him."

Michael trains his dark eyes to the floor and says nothing. He used to laugh and run when he lived with D.J.'s sister, Ms. Henson says. Since he's been back with his mother, he's become quiet and withdrawn, "like if you do something wrong, I'm going to slam you up against the wall," observes the social worker.

In a hot, stuffy apartment next door,

FIGHT Continued on Page 12

Fight

From Page 11

Michael's 2-year-old sister, M., is sleeping soundly on the bed. She's there because an 87-year-old neighbor worries D.J. will neglect to give the child a nap.

"I go get my baby every day," says Miss R., a tiny, white-haired woman who keeps the curtains pinned back with clothespins and a picture of Jesus on the bedroom wall. "I'm just in the world by myself. I'm the only one left of 10 children."

Ms. Henson is grateful for the watchful eye of Miss R. But she also holds the old woman partially responsible for these children's plight.

Last spring Ms. Henson obtained an emergency order to take D.J.'s children and place them with their aunt. She had received more than six reports that D.J. was high on drugs most of the time, leaving her children at home alone and often forgetting to feed them, change the baby's diapers or put M. down for her nap. The final straw came when Miss R. called and said the baby had a large burn on her forehead.

"[D.J.] said the baby fell on the concrete outside playing," Ms. Henson says. "We told her no, it wasn't true. The burn was V-shaped. I told her to take the baby to a doctor, but she didn't do it. We'd gotten so many calls from neighbors that finally I got the children picked up. I wanted to have the baby picked up because the mother's so crazy, because we've had so many reports of her alcohol and drug abuse, and her boyfriend's an addict."

D.J. herself had told Ms. Henson that sometimes her boyfriend "puts orange juice and cocaine on his tongue, swishes it around and shoots it in the baby's mouth."

Ms. Henson took the case to court, hoping to transfer custody of Michael and M. to D.J.'s sister.

"We got into court and told the judge the mother had drug involvement," says Ms. Henson. "We had repeated police reports, repeated hospital reports, we had all this documentation that people had reported."

"The judge clearly saw that the woman was a nut. She danced all over the courtroom. She was saying, 'Your honor, they're just trying to pick on me because they know I'm so cute.' And the judge comes back and says, 'Where do you have that she's not caring for her children?'"

Ms. Henson laughs. Indeed, she could not prove that D.J. wasn't caring for her kids because Miss R. took the stand and said D.J. was a satisfactory mother. Ms. Henson lost the case; the children returned to their mother.

JOHN SPINK/Staff

Vale Henson, a DeKalb County social worker, calls on one of her cases in a public housing project.

The elderly woman later told Ms. Henson that D.J. had threatened her. In fact, Ms. Henson says, the old woman did not want to give up caring for two small children who look to her for the only love and warmth they receive.

"The court wants solid, hard-core evidence," she says. "I don't have it. I already picked those kids up once on a whim. They only let you pick them up on a whim one time."

As Ms. Henson says goodbye to Michael, she assures him she'll check on him next week, although she knows she may not have time. Throughout the visit, he has followed her like a puppy, never speaking. Ms. Henson tells D.J. to stay away from booze and drugs. "I'll never do no more drugs. Heck no," D.J. says. "They couldn't give me a million dollars."

Driving out of the project, Ms. Henson says she's comfortable the children's lives are not in imminent danger. And frankly, that's about all she has time for. "We cannot save the world," she says. "I think after working this job for a while you learn to help those you can help and forget those you can't. Emotionally those kids aren't getting what they need. But you can't save the mental health of all these children. We don't have time. All you can do is hope to keep them alive."

(Postscript: The children remained with their mother for four more months, during which time the mother was hospitalized for a possible drug overdose. She subsequently abandoned them in a shelter for the homeless. Today Michael lives with his father. His little sister is in foster care.)

Well-trained child protective services workers know what signs to look for. "It's in the way children act," says Ms. Henson. "After a while you just know."

Georgia has 589 social workers to deal with the more than 39,000 reports of child abuse or neglect. The basic requirement is a college degree, although many, including Ms. Henson, have master's degrees in social work.

Once hired, workers receive one to two weeks of training. Some get special training in subjects such as sexual abuse, but many don't.

The Signs of Child Abuse

In recent years, the job has become increasingly dangerous, experts say. "You don't remove children from people's homes without creating anger," says Ms. Trussell.

When Ms. Henson visited one family where a child had been burned, the father pulled a sword on her. He told her he was Napoleon Bonaparte, then slashed a "Z" on the wall.

"He told me to get up and salute, and I stood up and *saluted* the man," Ms. Henson laughs. "I said, 'Yes, sir, aye-aye, sir,' and anything else he wanted me to say. Then I turned around and walked out and I told them I was not going back out to see that nut."

Generally the hazards are less severe, such as transporting neglected children in her car — children infected with lice, ringworm, scabies or impetigo. The department has issued the social workers plastic gloves, and Ms. Henson keeps a sheet in the trunk to protect the back seat.

The greatest hazard for most social workers, however, is an emotional one.

Bruises and Blows

Patrick was a fat-cheeked Gary Coleman look-alike of 3 when Ms. Henson met him.

She was assigned the case after a public health nurse noticed multiple bruises on the toddler's buttocks as she gave him routine shots. When Ms. Henson went to the house to investigate, the mother told her the child had been beaten by his paternal grandfather in Alabama, with whom Patrick had been staying.

"So I bought the story," says Ms. Henson. "I didn't have anything else to go on."

Three months later, she was called by Southwest Hospital and Medical Center, where Patrick had been admitted semicomatose from some kind of blow to the head.

That time, the mother suggested he had fallen off a stool in the kitchen. The woman seemed quite concerned, Ms. Henson recalls, yet "something didn't click right with that case."

> Georgia's child welfare system is failing to protect thousands of children as it is choked by mounting reports of abuse and too few resources to deal with them.

When she arrived at Patrick's house, the child was sitting on the sofa, his eyes rolled back. Even though the hospital had just released him, he didn't look right to her. She began making regular visits.

The week after he got out of the hospital, Ms. Henson found Patrick sitting on the same sofa, this time with a swollen arm. The child was clumsy, the mother said. Ms. Henson demanded that she take Patrick to the doctor, and the mother's boyfriend agreed to take him to an orthopedic surgeon. The physician found a spiral fracture, a break that is generally inflicted from twisting and a red flag to those who have been trained in the signs of child abuse.

When Ms. Henson called the physician, hoping he could help her build an abuse case, he instructed his nurse to tell her he would not have time to discuss his findings.

"I could not prove anything on this case," she says. "The mother was appropriately concerned in her voice. The doctor wouldn't help."

Nevertheless, she filed a petition in court, saying the child consistently received questionable injuries. Fulton County Juvenile Court Judge Romae Powell issued an order allowing Ms. Henson to have Patrick picked up.

But when she asked the Atlanta police to get Patrick, they refused, saying the order did not grant them proper authority and they would need some other type of clearance.

She had to get her supervisor to call Atlanta Police Commissioner George Napper before officers agreed to go to the house. When they arrived, Patrick was gone. The judge ordered the mother and her boyfriend to turn him over in court, and they did so the next day.

"The child is sitting up there with his arm in a cast, his eyes were rolled back in his head and they almost had to drag him in," Ms. Henson recalls. "I left straight from court — put that child in my arms and took him to Grady."

At the hospital, physicians discovered bilateral retinal hemorrhages behind both of Patrick's eyes, three fractured ribs and a spiral fracture to his arm. His buttocks had been beaten to a dark, leathery texture; his head was so battered and swollen, physicians had to put a shunt in his brain to drain off the fluid.

"I just cried," says Ms. Henson, who visited the hospital each day he was there. "I sat next to that baby's crib and cried."

(Postscript: Ms. Henson carried the medical reports to the Atlanta Police Bureau and got the couple arrested for cruelty to children. They served six months in jail. Patrick is now in the custody of his grandmother.)

A Father Who Molests Daughter

When she first started the job, Ms. Henson took cases such as Patrick's home with her at night, wondering if there was something she missed, something more she could have done. Often she combed her closets for clothes, sheets, pots and pans for the many people she felt were driven by poverty into a cycle of violence.

She's changed since then. "Honey, I take my hat off when I leave work," says Ms. Henson, a divorced mother of three. "I don't worry about these folks."

It's her way of surviving, she says. There are too many depressing cases, like the 4-month-old who recently underwent six hours of surgery at Grady Memorial Hospital for vaginal tears after a man had sex with her. That was a colleague's case, but in a recent six-month period, Ms. Henson had two other children under 2 with gonorrhea, a sexually transmitted disease.

Sexual abuse cases are particularly tough, she says. "These perverts never get prosecuted because the mama often doesn't support what the children are saying. It's hard working with these mothers because so often financially she's getting so much out of the deal."

The W.'s are a case in point. If it were up to Ms. Henson, Mr. W. "would be six feet under." She makes similar statements about his wife.

Mr. and Mrs. W. were high school sweethearts before they married more than 20 years ago. Three of their four children — a 9-year-old son and daughters, 16 and 17 — still live at home, a large brick house in an affluent DeKalb subdivision. He's a district manager for a large Atlanta corporation; she works for a bank.

On this typical day, Ms. Henson wants to stop by the W.'s house and check on the girls, who are under her protective custody by order of the court. In the winter of 1987, Mr. W. agreed to plead guilty to sexual molestation charges after admitting he'd been having sexual intercourse with S., his older daughter, since she was 9.

Mr. W. was placed in an Emory University program that treats sex offenders and ordered by the court not to go near the house or the girls.

The case became Ms. Henson's after S. told her story to a school counselor.

FIGHT Continued on Page 14

Fight

From Page 13

earlier this year

It was not the first time the girl had told of being abused

When the case was assigned to Ms Henson, she found on file a card dated 1979 that noted a pediatrician who had examined S reported she suspected sexual abuse The case was evidently closed after the mother told a caseworker that her husband had promised he would never have sex with their daughter again She promised to kick him out if he did

"That child stayed in the home six, seven years until it was reported again" Ms Henson says Now the family's beyond help, she feels As with many abused children, especially when the abuse has gone on a long time, the victims are attached to their father

"To both of them, basically, he's a wonderful dad," she says "She's sick of being [molested], but they love him to death The mother loves him They're one big happy family Isn't that sick?"

As Ms Henson weaves her car down the W 's tree-lined street, she spots Mr W 's company car in their driveway "If he's here, his butt is grass," she says under her breath "He's going to jail today Just wait I knew I'd catch them one day Those child molesters, I hate them"

Ms Henson rings the front doorbell, and Mr W — dressed in white shirt, tie and dark pants — answers She asks him what he's doing there, and he nervously tells her he's picking up his mail "I assume the girls aren't here" Ms Henson says to him "You're not staying here, are you, Mr W?"

"Oh no" he says Ms Henson is fuming as she drives to the nearest pay phone She wants to ask her supervisor if she can have him arrested that afternoon but her supervisor is at lunch While she's on the phone, Mr W zooms by

On the way back to the office, Ms Henson considers her options She could try to have him thrown in jail But why bother?

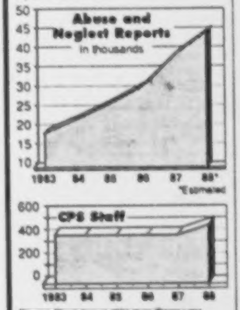
"If I had a protective mother, or if one of the kids wanted him out of their lives, but I'm going to bat by myself," she says

She learns later that under this particular protective order, the best she can do is get him charged with contempt of court

She feels the case is no longer worth her time "I have no leverage," she says "I have custody, but what does that mean? It means I see them once a month, and they don't want my help I think I lost this one"

Cases Surge, Staff Lags

Reports of child abuse and neglect increased an estimated 137% between 1983 and 1988, but the Child Protective Services (CPS) staff handling those reports grew by just 20%



Source: Department of Human Resources

MITCHELL BROOKS/Staff

In some of Georgia's child welfare offices, turnover is as high as 50 percent a year — or more "The job is extremely hard" says Ms Trussell

After nine years, Ms Henson earns an annual salary of $25,500

"That's how we value children in our society," says Douglas G Greenwell director of the state Division of Family and Children Services

The problem of child abuse and neglect in Georgia is far more complex than a lack of money, however

Workers such as Ms Henson say they are hamstrung in their efforts to protect children by uncooperative physicians, reluctant school officials, untrained police, inadequate foster homes, a complete lack of programs for abused children and their families, a criminal justice system that doesn't prosecute, and laws that place a higher premium on animals than on children In Georgia, it is a felony to kick a police dog but normally only a misdemeanor to kick a child

Critics of the child welfare system say caseworkers often fail to remove a child from his home before it is too late Some blame recent federal and state legislation that puts a greater premium than ever on keeping families intact In 1980, Congress passed the Adoption Assistance and Child Welfare Act to cut back on the number of children living out their lives in foster care

But that law presumed that a myriad of services would be pumped into troubled families to get them to stop abusing their children, such as drug counseling, day care, housing and parenting skills

Georgia has done a good job of keeping families together, state officials say, but the support services often haven't been there

"We may well be saying 'Hey, we want everyone to stay home,'" says Gerald V Gouge, chief of the state's Child Protective Services Unit "'But we don't have the resources to help you'"

"Looking for His Daddy"

For all her toughness Ms Henson gets attached to the children she's hired to protect In her Decatur office, she keeps many of their pictures tacked to the office divider that surrounds her desk

During lunch on this typical day at a Po Folks Restaurant, her eyes mist as she recounts the story of Leo, a 9-year-old who has raised himself in the shadow of an absent alcoholic father

Leo is one of the rare cases in which Ms Henson has taken steps to have parental rights terminated so the child can be put up for adoption The process is complex and state officials say they attempt it in fewer than 5 percent of the cases

By the time he was referred to Ms Henson, Leo was getting himself up in the morning, going to school alone and coming home to an empty house at night "He even fried pork chops," Ms Henson says

He came to authorities' attention when he was brought alone by ambulance to Grady Memorial Hospital after he fell chasing a dog When hospital staff asked whom they should call, the child told them he had no one but his father He did not know where his father worked or stayed

Ms Henson sat with Leo through three court hearings

"Leo sat there in the window at court looking for his daddy 'Is he coming?' he would ask me I cried I had to go in the ladies room and cry

"I wrote the father two horrible letters and told him what I thought of him," she says "I said, 'We're not going to make you take Leo, believe me But come to court, just come and say hi to him' He never came"

Leo has been with a foster family for three years The family wants to adopt him, but recently an aunt appeared "out of the blue," says Ms Henson, and she wants him By law relatives get priority, despite what the child wants

Ms Henson considers Leo a success story because right this moment he's with a family that seems to love him.

JOHN SPINK/Staff

Social worker Vale Henson visits a home in DeKalb County where children live with flies, garbage and gaping holes in the ceiling, the yard strewn with garbage.

and he appears to be happy and safe. Such stories keep her going, even make her upbeat about her job.

She's made her last stop of the day at a house located worlds apart but within walking distance of the DeKalb courthouse. Inside, flies swarm over garbage, old shoes and shirts that are strewn about. For furniture, there's a car seat and a couch with no cushions. Sides to cartons have been tacked to the ceiling in some places; there are gaping holes in others.

Four boys, including 8-year-old twins, are being raised here. They are the sons of a 37-year-old woman and a 68-year-old man.

On this particular day, Ms. Henson asks Mrs. S. how the children did in school. Dressed in a stained blouse and skirt, the mother says she doesn't know. She's not even sure where they go to school.

There have been reports of abuse, but Ms. Henson has no intention of taking the children away. She did that once before, and the twins ran away from foster care and found their way back home.

"Our goal is to keep these families together," she says. "Because nobody wants to adopt any of their children. No matter how bad parents may be, they still have rights."

Furthermore, she says, Mrs. S. loves her children. "There are cases where we can tell the mother could care less about her children, but she nurtures those children. She's limited, mind you, but you cannot put your middle-class values on these people. You have to look at what do I have better to offer that family.

"For this family, all we can do at best is keep them from beating the kids, keep the lights on, keep the utilities on, keep clothes on the kids' back, keep food in that house and encourage them to send the kids to school. That's the most we can offer."

It's close to quitting time, and she's happy to be driving back to the refuge of her office. "It's nice to come back, away from the real world," she says as she walks inside.

Yet she can't help ending the day remembering how it began. "I wonder where V. is," she says, throwing her files on her desk. "I hope she doesn't go killing those kids."

Emergency Shelter Is Bursting at the Seams

By Jane O. Hansen
Staff Writer

SUFFER THE CHILDREN

PART 3

In the shadow of downtown Atlanta, a tiny 3-month-old lies in a room of wall-to-wall cribs, sucking her thumb and staring at the ceiling. Abandoned by her mother at the hospital where she was born, she rarely cries and doesn't seem to be growing.

Across the hall in the TV room, a severely mentally retarded boy is watching "Sesame Street," surrounded by a dozen toddlers and small children. The 15-year-old, left here by his family close to a year ago, is dying from a fatal disease, has periodic seizures and openly masturbates.

In the same room, a plump little boy wraps his arms around Kimberly Mosteller's legs. "This one right here is very active," the child care worker says of the 20-month-old. He didn't used to be. Beaten regularly at home, when the baby boy first arrived two months ago he slept a lot, sat very still and hardly uttered a sound.

These three children are among more than 60 crammed on any given day into the Fulton County Emergency Shelter, located a few minutes south of Atlanta's gleaming glass towers. The facility is designed to house only 30 abused and neglected children, but one recent night 86 babies and children stayed here. Among them were 28 infants and babies who were stacked two and three to a crib. Older children slept on the floor on hastily made pallets.

One of 22 such shelters in Georgia, this orange-brick way station represents today's version of yesterday's orphanage. It is the dumping ground for many of Atlanta's unwanted children — a place where babies sleep on the same floor as teenage drug dealers, a place where abused and neglected children are supposed to stay for days but often spend months.

"It's out of sight, out of mind," says Richard L. McDevitt, president of the Georgia Alliance for Children. "Who's going to care?"

Since 1983, the number of children placed in emergency shelters has jumped 84 percent in Chatham, Clayton, Cobb, DeKalb and Fulton counties, according to a recent report.

Many shelters are so overcrowded they must turn needy children away. Last year the Alcove Youth Shelter, a privately run program in Monroe, served 207 children. It closed its doors to 159 because of lack of space.

"We are in a crisis situation," says Jane B. Jones, deputy director of the Cobb County Department of Family and Children Services. The county's overcrowded emergency shelter in one recent month had to turn away eight of her agency's children. "We need a place that cannot say no to us."

An 'Appalling Situation'

The Fulton County shelter doesn't say no to anyone, but it pays a price. With too few staff and not enough resources, children staying here have been dirty and infested with lice, according to Dr. Barbara Bruner, director of Grady Memorial Hospital's pediatric emergency clinic.

At times, the crowded conditions have been life-threatening.

When a 4-year-old girl recently became ill, shelter staff took her to Grady, where physicians promptly diagnosed her condition as a seizure and shipped her back with medication.

At the shelter, the little girl lay alone upstairs on a cot. "She stopped talking and was just lying there," says Sheila Nichols, one of the shelter's assistant supervisors. "We were just trying to monitor her the best way we knew how, handling some 60 kids up there, kids running all around."

In fact, the little girl's seizure had been a stroke that had left her partially paralyzed and unable to swallow. And when shelter staff neglected to give the child a dose of her medicine — in part because they could see she was having trouble swallowing and were afraid she might choke — the child had another stroke.

In a recent emotional outburst before the state Board of Human Resources, Dr. Bruner decried the state's largest emergency shelter as an "appalling situation," one that "should never be permitted."

"We report parents for child abuse for doing what we're doing to these children in this shelter," she said.

Wayne Stokes, the shelter's director for 10 years, agrees. "We've far exceeded the rules and regulations, but what do you do?" he says. "We shouldn't have to pack them in like this."

In Georgia, all but four of the emergency shelters for children are financed by private funds, not public. Many child advocates say the state government should chip in more, that private giving is limited. "People will give money for an animal shelter, but not for a child shelter," says Juvenile Court Judge Virgil Costley Jr. of Newton County.

Fulton County's shelter is operated mostly with county funds, making it one of the four that are publicly funded. The state contributes about $440,000, and Fulton makes up the rest of the shelter's annual $1.3 million budget. Local officials say they need a lot more.

"What has consistently been a problem in Fulton County in meeting these increasing demands has been financial support from the state so that we are not expected exclusively to rely on the local property taxpayer," says Fulton County Commission Chairman Michael Lomax.

According to state officials, the county has not asked for more funds.

Under state law, publicly funded shelters are not regulated or licensed by the state unless they ask to be. Fulton County has not made that request, either.

"I'll be honest with you," says Ralph Mitchell, director of the Fulton County Department of Family and Children Services. "We wouldn't pass."

Worker Becomes 'Mama'

It's 11:00 a.m. and a daily ritual is about to begin.

Babies are lined in eight highchairs against the wall of the Fulton County shelter. Like maestros, two child care workers raise their spoons, and a feed

ANDY SHARP Staff

Laura Parker hugs J.O., a 9-month-old boy brought to the Fulton County Emergency Shelter with burns, probably from an iron. "You can hold onto me," croons the child care worker.

ing frenzy commences. Babies wail and flail about as the child care workers feed two and sometimes three babies at a time, shoving in food as quickly as possible.

"They all want to eat at the same time," laughs Mr. Stokes, a former defensive end for the World Football League in Chicago. "It's probably one of the most hectic times there is."

It's also one of the lighter moments at the shelter, where frustrations are more frequent than levity and regimentation is more practical than one-on-one attention. It's not what anyone wants for these children and babies, who flock around a stranger wanting to touch and be touched.

"It breaks your heart," says Mr. Lomax, a frequent visitor to the shelter. "The problem has been that there really hasn't been very much public attention to these matters. We don't have a public outcry."

Ideally, child care workers want to place children like these in foster homes, not institutions. "They need a home and people to relate to," says Mr. Mitchell. "Here it's custodial, supervisory. It's not that family, and the more they're without that, the more we damage them."

But the pool of people willing to be foster parents is drying up, despite the county's offer to pay for day care as a way to recruit working couples.

"We have the money to accommodate more foster families," says Mr. Lomax. "We just don't get the community response."

At the same time, babies are beginning to swell the ranks of Fulton County's abused and neglected children — the direct result of the crack epidemic, officials say. One recent resident of the shelter was a baby boy who was picked up when police officers raided his parents' drug den. They found drug syringes in the baby's crib.

"I hate it," says Phyllis T. Williams, a child care worker. "I wish there was some way we could get rid of the drugs."

Ms. Williams is one of four full-time workers who, against a backdrop of fussing and crying, tend to the needs of as many as 28 babies at once. She has been here four years.

"It's hard, it's real hard," she says, holding a 10-month-old boy who has recently started calling her "mama." "You hate to see the children like this. Look at him. How can I give him back?"

SHELTER Continued on **Page 18**

Shelter

From Page 17

Ten days ago, police officers dropped off 9-month-old J.O., a plump baby boy with a wild tuft of hair on his head and burns on his right forearm, forehead, cheeks and head.

This particular day, J.O. won't eat the baby food before him or stop crying until one of the child care workers, Laura W. Parker, picks him up.

Unexplained Burns

"You can hold onto me," she tells him, sitting him in her lap and offering him a plate of adult food. The infant grabs a fistful of corn bread and green beans and stuffs them into his mouth.

"This baby's not used to baby food," Ms. Parker says. "His mama probably stuck some Church's fried chicken in his mouth and went on about her business."

How J.O. got burned is not entirely clear, Mr. Stokes says. Only sketchy details were provided by the caseworkers, but they suspect he was burned with an iron. And they believe the mother's boyfriend did it.

Apparently the man had argued with the baby's mother, then taken J.O. and his 7-year-old brother someplace and abandoned them. The children were picked up by police and brought to the shelter.

As Ms. Parker examines the baby's body, she discovers what appear to be neat little pinholes in the tips of several of his fingers. A couple of the holes look infected.

"You know, the only thing I like about this job is that I don't usually come in contact with these parents," Ms. Parker says. "Because if I did, I'd be in jail."

Babies and Drug Dealers

This shelter, as others, was designed as a 72-hour emergency refuge for children such as J.O. But around the state, shelters are increasingly being used as more permanent placements, not only for abused and neglected children endangered by their parents, but also for mentally ill children, mentally retarded children, unruly children and criminal children.

Emergency shelters have evolved into "modern-day orphanages," says Mr. Lomax — depositories for other agencies' shortcomings. Juvenile Court judges, lacking space in detention facilities, send youths to shelters. State mental health centers, with too few options for mentally ill and retarded children, buy time by sending them to shelters.

The shelter's nursery is located on the second floor, just down the hall from the bedrooms of rowdy, troubled teenagers who occasionally bust holes in the walls or take a pipe to the light fixtures.

The babies live in a well-lit nursery where cribs and bassinets line walls that are decorated with rainbows, clowns and Big Bird. But staff say they lack basic baby equipment — playpens, baby walkers, safety gates, even toys. And this is not the environment that most people would want for their children.

Last weekend, a 16-year-old drug dealer was brought to the shelter because he needed "protection." There was a contract out on his life.

"We're not set up for that," says Mr. Stokes, who fears for the safety of the other children as well as his staff. "Drug dealers — they play for keeps. Drug dealers play by a different set of rules. They don't care if someone is a kid."

Many of the children — particularly the infants — have lived out most of their lives at the shelter, staying for months at a time. By the time one baby boy left, "I cried, Mr. Stokes cried, everybody cried, we got so attached to that baby," says Ms. Parker. "I said I would never do this again."

Jeffrey, a severely mentally retarded 15-year-old, lived at the shelter close to a year. One recent day, as Mr. Stokes climbed the stairs to the second floor, Jeffrey fluttered his hands, smiled and playfully slapped a nonplused Mr. Stokes in the face.

"You have to watch him," Mr. Stokes explains. "He doesn't do anything to the children, but he has seizures. They see him having seizures and they don't understand it, especially the smaller children. Then he masturbates and does all the things some retarded people have a tendency to do. We had three children like that at one time."

No one wants Jeffrey. His aunt can't handle him anymore. And the state says that even though it has institutions for mentally retarded people, for some reason none in Georgia is suitable for Jeffrey. (He was recently moved to an institution in Florida.)

Where to Call to Help

If you are interested in becoming a foster parent, call your county Department of Family and Children Services for more information.

The foster care number at the state office in Atlanta is 894-2891. In metro Atlanta, the numbers are:

- Clayton — 473-2300
- Cobb — 429-7600
- DeKalb — 371-3300
- Fulton — 752-8970
- Gwinnett — 995-2100

'Makes Me Not Sleep'

Like other shelter directors, Mr. Stokes is alarmed by the problems being laid at his doorstep and his staff's capacity to handle them.

Yesterday's orphans were often products of their parents' untimely deaths; today's shelter children are more often victims of their parents' violence or negligence. They need more than a bed and some food.

"There's so many children and not enough places for them to go," Mr. Stokes muses. "And they're so needy. If they're not traumatized by what they've gone through as far as the abuse, then they're traumatized by being taken from their homes and families."

Daily, his staff members face the traumas of 6-month-olds whose fathers have had sex with them, 3- and 4-year-olds who arrive with cigarette burns on them, children whose skin sags from near-starvation. For that they earn a starting salary of $11,000 — less than a prison guard, less than a school janitor, less than a school cafeteria worker.

'Shatters the Delusion'

"This certainly shatters the delusion that we're a society that cares for its children," Mr. McDevitt says.

Besides the heartbrea[illegible]e children bring with them to the sh[illegible]r, they often leave under less than [illegible]al circumstances. Shelter directors complain that too often the courts and child protective services workers are quick to return children to the same abusive homes they were removed from.

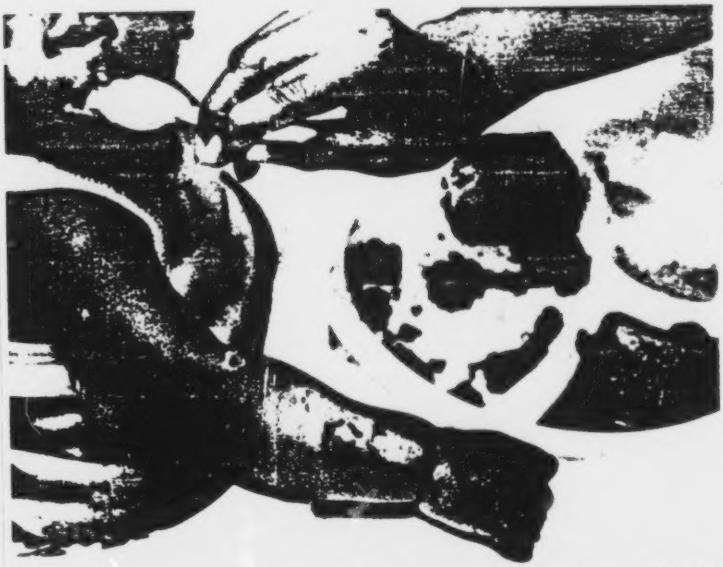
The little 4-year-old who had the stroke at the Fulton County shelter had been brought there with her brother because their grandparents had allegedly been abusing them. After the child's second stroke, the two were simply sent home.

"Isn't that ridiculous?" says Mr. Stokes. "After all that, they were turned back to the grandparents."

Despite her close contact with children who often confide in her, Donna Lane, who directs the Gwinnett County emergency shelter, says judges rarely ask for her input into whether a child should be returned home or placed in foster care. "I have asked for that," she says. "And I have not been invited."

She recalls a 6-year-old child who arrived at the shelter with such severe bruises "that you could see the strap marks on that child." In less than three days the courts sent her home.

"It makes me not sleep at night worrying about these kids," Ms. Lane says.



ANDY SHARP/Staff

J.O., a baby unaccustomed to baby food, is offered adult fare at the Fulton County Emergency Shelter. He entered the shelter with burns on his arm, cheeks and head. "The parents got so many rights and the kids have none," a child care worker complains.

Besides the heartbreak the children bring with them to the shelter, they often leave under less than ideal circumstances. Shelter directors complain that too often the courts and child protective services workers are quick to return children to the same abusive homes they were removed from.

Less than 30 minutes after Ms. Parker discovered the pinholes in J.O.'s fingers, the child welfare agency has called to say that the baby is being returned to his mother.

According to Mr. Stokes, police officers are hoping the woman will file criminal charges against her boyfriend. Ms. Parker and the other child care workers don't understand why the police don't go ahead and file the charges themselves.

"The mother's not going to stay away from that boyfriend," Ms. Williams says.

The women all chime in at once. "If they can get away with this, then they'll do it again," says Christine L. Oliver of J.O.'s parents. "The court always gives them back. It's like a losing battle. The parents got so many rights and the kids have none."

J.O. is calm now as he sits on Ms. Parker's lap. She's clipped his nails and put cream on the burns that have not had time to heal. He's put his arms around her neck and patted her on the head.

"You're going to leave me, baby, and then what are you going to do?" she says to him, dressing him to leave. She pulls on his red socks. "The next time it's going to be worse. This baby may not get to come back."

Staff writer Cynthia Durcanin contributed to this article.

ANDY SHARP/Staff

Wayne Stokes, director of the Fulton shelter and a former pro football player, cuddles a toddler. "There's so many children and not enough places for them to go," he says.

Life at the 'Strickland Motel'

Officials Count On Marietta Housewife to Take The Toughest Foster Children

By Cynthia Durcanin
Staff Writer

> 'Most everyone wants the cute little girl that does a little curtsy. I don't get any pleasure out of that type of child. I want a kid I can help.'
>
> **— Doris Strickland**
> **Foster mother**

A 10-year-old boy with red curls and freckles breezed into the room. Skidding to a stop, he wrapped his spindly arms around Doris Strickland's middle-aged frame, hugged her at the hips and disappeared into another room.

"While he's smiling at you, he's putting a knife in your back," Mrs. Strickland cautioned.

The comment is close to fact. Doris Strickland tells of the time when the same boy held a butcher knife to his tiny wrist and threatened to kill himself.

"I said, 'Well, darling, blood never scared me,'" Mrs. Strickland recalled. The child then vowed to choke himself. "I told him it wouldn't work because 'I don't believe you have the guts to stand the pain.'" The boy finally snapped, "Well, I'll hire it done."

Mrs. Strickland brought the conversation to an end with, "That won't work either, because you don't have any money to hire anyone."

At 56, Doris Strickland is no longer rattled by suicide threats. Nine years after she began, and after caring for nearly 300 children, the Marietta housewife has the distinction of being the woman officials can count on to take the toughest of tough foster children into her home.

Almost by default she is compensating the state for its shortage of group homes with her unofficial group home. Over the years, Mrs. Strickland has cared for as many as a dozen foster children at a time, ranging in age from 30 days to 17 years. They've stayed anywhere from a day to seven years.

Her selflessness and willingness to help others even as her own world is crumbling around her have elevated her to a high level of esteem among social workers.

"She causes me to be uncomfortable with myself because she makes me realize she's action and a lot of us are just words," said Diane Woods, director of Juvenile Court services in Cobb County.

It was the 1979 death of her son, Bill Jr., 26, in a crash of a small plane that led her to become a foster parent.

The death of her husband, Bill, in January led Mrs. Strickland recently to take a break from foster care, and her foster children were farmed out to various state institutions and shelters.

Bill Strickland died of a heart attack after rushing to the scene of an accident involving Mark, one of the foster children who remained with the family after he came of age.

Amid her grief, she tended to Mark, who was in a coma for two months, and continued to care for as many as 10 foster children until early May.

Now she is back at it. Last Friday, after a break of just three weeks, she reclaimed one of the children who had been farmed out, a 14-year-old Vietnamese boy who wasn't doing well at the shelter where he was staying, she said.

Rules to Live By

Doris Strickland takes in the toughest of foster children at her home in Marietta, but once they step through her doorway they live by her rules, and those rules can be as tough as the children. Punishment rules ranges from suspension of television privileges to work in the garden. Some examples of her rules:

- No alcohol or drug use
- No fighting
- No cussing
- No Ozzy Osbourne
- Clean up your own mess
- Do your own dishes
- Good grades, completing chores and getting along are prerequisites to dating
- Prospective dates must produce a driver's license and proof of insurance
- Television and Atari privileges hinge on chores
- Homework hours must be adhered to

Among those who go through foster homes the way some children go through tennis shoes, her name inspires both fear and love. Streetwise kids beg not to be sent to Mrs. Strickland's. But they often end up there because no one else will take them. And after they've been there awhile, they usually want to stay.

She has suffered unintended blows while mediating fights and taken a few punches that were intended for her. Her charges have armed themselves with knives while fighting over what to wat[illegible]n television, tried to burn her house down, destroyed interior walls and jammed the plumbing at a cost of $2,000.

"When I started, I had wall-to-wall carpet without a spot. Now I don't have any carpet left," she said.

Her two most notoriously difficult charges were Jacky and Mark. Today, Jacky, 21, and Mark, 22, are permanent members of her family.

When Jacky arrived at 15, he was the "scroungiest, orneriest, get-next-to-your-skin aggravating kid that ever existed," Mrs. Strickland recalled. "I used to pay Mark to take him outside just to get him away from me."

Mrs. Strickland tamed the two the way she tempers all of her problem children, with work. "One of the things teenagers are afraid of, what scares them to death, is work," she said.

She once roused a group of teens at 6 a.m. and had them planting collard greens, peas and carrots until sunset. The few who tried to get away got extra work. "The next day the rules were followed to a T," she recalls.

Mrs. Strickland believes that not

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ANDY SHARP Staff

Doris Strickland picks collard greens with two of her foster children. The gardening yields self-esteem as well as vegetables, she says: "Those plants are theirs. Once they've worked that garden they love it. They refer to it as our garden, our plants, our apple trees."

only vegetables but self-esteem can be cultivated in the garden. "Those plants are theirs. Once they've worked that garden they love it. They refer to it as our garden, our plants, our apple trees."

The strictest rule pertains to a musician. "I do not allow Ozzy Osbourne in the house."

Come home drunk, and she calls the cops. Dating privileges must be earned and prospective dates must produce a driver's license and proof of insurance before taking out one of Mrs. Strickland's charges.

The "Strickland Motel," as she calls it, is not a fancy place. Rules are posted in crayon throughout the house, large industrial-size containers of generic food clutter the kitchen, and most of the children sleep in an attic that has been converted into a loft. Air conditioning is a luxury the "Strickland Motel" cannot afford.

The children who call it home arrive in despair, their spirits long ago broken by incest, abuse or neglect. Drugs and alcohol are often the crutches of their troubled childhood.

Given a choice, Mrs. Strickland will always favor the tough foster kids. "Most everyone wants the cute little girl that does a little curtsy. I don't get any pleasure out of that type of child. I want a kid I can help."

Social workers say she works well with troubled children because she understands their anger. "They're mad because the law comes and removes them from their house and they didn't do anything. And the parents are allowed to stay at home," Mrs. Strickland said.

At the same time, Mrs. Strickland acknowledges that most people don't have the patience to do what she does.

"It's not the money," she said.

She receives $10 a day in room and board for each child and a one-time clothing allowance that varies between $150 and $300, depending on the age of the child.

"I can feed a child on $10 a day, give them baths, heat, the necessities of life," she said. But the state does nothing to cover recreational needs and the destruction that follows when teens become restless — such as the plumbing debacle.

Despite the many difficulties of caring for so many children, Mrs. Strickland knows she's the end of the line for many youths. "I feel like if I don't do it, nobody else will."

"These kids think that I'm fair. But I tell them that's not true. I'm not fair. I don't even try to be fair because the world is not fair, never was and never will be."

Longing for Home, Longing for Family

By Jane O. Hansen
Staff Writer

SUFFER THE CHILDREN

PART 4

Michael Steven Harmon was raised by a cold and unforgiving parent.

The kind who placed him with strangers when he was just 4, then had him locked up as a teenager. The kind who would meet him at school with his life's belongings in a paper sack and the news that another family wanted to "try him out." The kind who never bought the child a baseball glove or a school picture because it cost too much. The kind who warned caring adults not to shower love on Michael because he might get attached. And the kind who, when he finally grew up and fathered a child of his own, took that child from him and gave it away, telling Michael he was too damaged to make a fit parent.

Michael, 19, was raised in foster care. His parent was the state of Georgia.

Today Michael — along with thousands like him — stands as testament to a foster care system that frequently doesn't work. It is a system intended as a temporary solution but one that too often becomes permanent. It is one that is supposed to offer a haven to child victims of physical and sexual abuse but too often victimizes them further.

In Georgia, the foster care crisis has spawned living situations for children that are sometimes worse than those reserved for the state's prison convicts. With too few foster families for a growing number of abused and neglected children, foster care for some Atlanta children means sleeping on floors at lice-infested emergency shelters, the latest dumping ground for the children nobody wants.

One recent night, the Fulton County Emergency Shelter — built to handle 30 children for up to 72 hours — housed 86, including some who have lived there for months and one retarded boy who lived there almost a year. A third of the children were babies, sleeping two to three in a crib.

Other babies are being warehoused in hospitals — sometimes by parents who abandon them, sometimes by social workers who have nowhere else to put them. Atlanta's child welfare workers increasingly have difficulty finding foster parents for perfect babies, let alone damaged ones. And in the face of AIDS and the cocaine epidemic, the damaged ones are on the rise.

Of the 6,725 Georgia children in foster care as of last month, 76 percent of them were there because they were physically or sexually abused, neglected or abandoned — in the majority of cases by their parents.

Once in foster care, many children are victimized again. According to the Georgia Department of Human Resources, last year there were 88 confirmed reports of children abused in foster care. One national study puts the rate of abuse among foster children at 10 times that among children in the general population.

Those who are not physically abused are often emotionally bruised by a bureaucracy that bounces them from home to home or from institution to institution.

Raised in rejection, people such as Michael lack self-esteem, have difficulty forming trusting relationships, and worse.

"What you have is a situation where we as taxpayers are incubating tomorrow's criminals in the name of saving children," says Robert L. Woodson, president of the National Center for Neighborhood Enterprise in Washington, D.C. He estimates that 30 percent of children who experience multiple moves before the age of 8 wind up in the nation's jails as adults.

"The problems are circular. It's like building a hurricane."

Michael's life has been such a storm.

'Didn't Know Where I Came From'

No one knows precisely how old Michael was when his mother, an alcoholic, gave custody of her son and his five brothers and sisters to the Clayton County Department of Family and Children Services. Michael thinks he was around 2. Social workers who knew him say maybe 4.

His life's record — stored for years in Clayton County, then moved with Michael to Gwinnett County — has been destroyed. It is most counties' policy to get rid of the records three years after a child leaves their custody. There's just no room.

For many years, Michael didn't even know he had brothers or sisters. Like 40 percent of the children in Georgia's foster care system, Michael was initially separated from them.

"At first, I didn't know nobody," he said in an interview earlier this year. "I didn't know where I even came from."

His first memory as a child is wishing he had a family of his own. "I had friends, you know. I'd see their families."

Michael has straight blond hair, blue eyes and the words "love" and "hate" tattooed across the backs of his fingers. The father of two children, he looks like a child himself with the soft peach fuzz of a boy at puberty. When he talks about being raised by the state, he speaks softly and matter-of-factly. He does not complain about the only life he's known.

"Most of them was pretty good," he said of his many foster parents, dragging smoke from a Marlboro cigarette. Then he added, "It's just whoever wants you gets you. That's all it amounts to. If they don't like you, they call up somebody and they come and get you and take you somewhere else."

One day, when he was about 8, a social worker came to the elementary school where Michael was a student. He was living at the time with a family he can't remember now, and she brought his belongings to school in a paper bag. As Michael recalls, she told him that a new couple "wants to try you out for the weekend."

It was during the Christmas holidays, and the couple wanted to take Michael to Minnesota where their family lived. He didn't want to go. "I was crying," he recalled. "They told their people that I was their son and everything."

When they returned to Georgia, the

couple gave Michael back to the county "They didn't want me no more"

'You're Not Family'

In most of Michael's homes he was not the only foster child Sometimes he shared a room with as many as six other children, and it was not unusual for the orphans to be relegated to a separate table from the family during mealtimes In one home, Michael and the other foster children slept and ate in the basement while the husband wife and their children lived upstairs

When he was about 4 he remembers sitting in a highchair most of the night because he refused to eat a bowl of coleslaw One foster mother, the one he liked the least fed him tomato sandwiches three meals a day "I hate tomatoes now," he said

According to Michael, that same woman broke the arm of another foster child Jamie "She used to have a big ol' paddle," Michael said "It was in the summertime Jamie was about 12"

But whenever child welfare workers visited the home to check on the children, no one spoke up "Everybody was scared to say anything We knew when they left she was the same old person"

According to the county the woman is no longer used as a foster mother Today Michael believes most of his foster parents were in it for the money (The state pays foster parents $10 a day for each child they take)

"You're not actually no family You're there simply because they're getting something for you," Michael said "Kids don't know that The only reason I know it now is because I look back and I know what they did I didn't back then I didn't know why they was treating me like that"

The hardest thing was living up to each family's expectations "See, when you go into a home, these people already got their mind set on how they want you to be," he said "I went to some foster homes where all they wanted me to do was study books and stuff like that I just didn't like going in there because you didn't know nobody They just showed you where your room was at It was like the Army or something That was where you were stationed You'd go to sleep at night and you didn't know if somebody was going to come and get you at 3 in the morning and bring you somewhere else"

Baseball Uniform, School Pictures

By the time Michael was 11, he'd been in at least seven foster homes, according to Beverly S Read, one of Michael's former foster mothers and the only one he still sees

When she got him, Michael was an angry, sullen child who was doing poorly in school He cried most of that first day at her house in Jonesboro County social workers had made him leave his dog "Little Bit," at his last foster home And he didn't understand why yet another family he'd been living with — a military man and his wife — had given him back to the county

NICK ARROYO/Staff

Michael Harmon, who spent years in foster homes, has two tattoos on his hands: "love" on the left and "hate" on the right. Last month he began serving a two-year prison sentence for breaking into a house and a car.

"Michael was in a home that he had felt comfortable in," Mrs Read said "But they were not comfortable with Michael They were military, didn't have any babies of their own They wanted babies, which 90 percent of the foster care parents want But rather than sitting down and explaining that to him, the county just picked him up and moved him What did that do for his self-esteem? He felt that he'd done something wrong He told me over and over again, 'I didn't do anything wrong I was good I tried real hard'"

When Mrs Read first got him, Michael lied a lot, particularly about the food he foraged and stored in his room "He'd get up from the table and take biscuits and put them in his drawers," she said "I don't know what it is with foster children, but they have this overwhelming desire to hide food Ask any foster parent I guess they don't feel they'll get enough And I would get aggravated I'd say 'Michael, you can have as much food as you want, but don't take it to your room' It was funny until you found a 10-day-old peanut butter sandwich upstairs"

That year at the Reads', Michael gained a full year and a half at school "He was stable," Mrs Read said "He knew we weren't going to let them move him, and that we'd fight if they tried I told him that, that I'd do everything And it made a big difference"

At night she tucked him in kissed him good night and told Michael she loved him He told her he didn't believe her

One of the happiest times of Michael's childhood came that year when he played on the baseball team "He could run like the wind," Mrs Read said "There was no one who could catch him when he ran"

At first, the county Department of Family and Children Services refused to pay for his baseball glove and uniform "I had a fight with them," she said She eventually got them to pick up the tab for the uniform "They didn't want him to have any stability like that They gave the argument, 'What if we have to move him?'"

LONGING Continued on **Page 24**

Longing

From Page 23

The Reads, who have their own trucking business, also bought Michael his first school picture School pictures are an unallowable expense for foster parents, one that cannot be charged to the state As a result, many foster children never get them

The team lost every game that season But Michael, a fifth-grader at the time, didn't care "I was there, my husband was there," Mrs Read said "We were clapping and cheering him on He was doing something and for the first time in his life, he could show the other kids that he had some place to call home He didn't care that they lost just so he was a part of it"

The year and a half at the Reads' was an oasis for Michael It ended when his father came back into his life

Mrs Read believes the county nagged Michael's father into taking his son back "I think they were just tired of messing with it"

Michael was ecstatic "I always wanted to be with my people," he said "I'd see Beverly's family and everything, and I'd wonder what it would be like if my family was still together But it wasn't like what it was supposed to be"

Michael cried the day he left Mrs Read's So did Mrs Read "We all cried," she said "My boys gave him something, each one They were upset Everybody was upset Michael had mixed emotions He was happy about his father, yet torn I told him I hoped everything would work out OK and to keep trying in school

"I always told him that," she laughed "He hated it"

'I Just Didn't Care Anymore'

She didn't hear from him for almost four years Michael lasted with his father in Gwinnett County for six months Then the father, an alcoholic like Michael's mother, gave him back to the county

After that, said Michael, "I just didn't care anymore"

For the next four years, he was in and out of trouble — stealing bicycles and cars, skipping school and running away from foster homes Eventually he wound up serving time in the state's youth prisons, called "youth development centers" He spent eight months in the Augusta YDC after running away from the Atlanta YDC

"There was nobody else in there for running away," he said "They just run out of places to put me"

Law enforcement officials remember Michael well "I wouldn't trust him as far as I could throw him" said one who wants to remain anonymous "He is manipulative, not to be trusted and in general, uses any means available to further his own gain"

Said another "Michael brought on a lot of the problems himself"

During his early teen years Michael lived periodically with the Gwinnett County probation officer assigned to him A woman in her 30s, Patricia Wheeler was arrested by Gwinnett County police in 1982 and charged with contributing to the delinquency of a minor after she and Michael were found in bed together, according to law enforcement officials Michael said she wanted to marry him He was 14 at the time

"As I started getting older, I started getting worse," he said "If she didn't give me what I wanted, like money or something, I'd hit her and stuff like that I always was getting in trouble She let me do anything I wanted to do"

Ms Wheeler was subsequently dismissed from her job because of her relationship with Michael, law enforcement officials said After the couple spent some time in Florida Michael said, she got fed up with his refusal to marry her and bought him a Greyhound bus ticket that got him as far as Tampa He spent a week living in laundromats before he got enough money to return to Atlanta

Michael's father hasn't gotten in touch with him since he turned him back over to Gwinnett social workers "I don't blame him" Michael said "Deep down I know he really loves me"

He does see his mother In fact, said Mrs Read, Michael takes care of his mother, a woman largely dependent on drugs and alcohol, according to Mrs Read and Michael

"My mom, she ain't never had nothin'," Michael said "She don't have furniture Whatever she's got, I gave her She's just pitiful I love my mama you know I always love my mama because she's my mama She's throwed me out when I didn't have nowhere to go before You know, I was out on the street She just don't understand what it is"

It was Michael's parents who stood in the way of his ever being adopted into a permanent home They did not want to give up their parental rights and in Georgia, those rights are often left intact even if a parent does nothing but send a birthday card once a year

Increasingly, critics say the rights of some parents are being protected at the expense of their children Children such as Michael, who could have been

JOHNNY CRAWFORD/Staff

Beverly S. Read, one of Michael Harmon's foster mothers and the only one he still sees, says there 'is goodness in him.' She blames many of his problems on the government's handling of such children.

adopted when he was a toddler are instead consigned to "drift" in foster care throughout their formative years

"If they would at least terminate rights on the younger children, they could save lives," said Mrs Read "Michael adopted at 3 would have stood a chance"

Ironically, Congress passed the Adoption Assistance and Child Welfare Act in 1980 to cut back on the unnecessary placements of children in foster care Under the law, states must make "reasonable efforts" to keep families together

Now critics say the law has gone overboard, keeping families intact at the expense of children's lives

Michael believes his life might have been different if he'd been adopted early on, before he grew old enough that his only goal in life was to find "my people"

"Yeah, I don't believe I'd be like I am now," he said last winter, his head down as he sucked periodically on his baby's pacifier "I don't believe I'd ever been in jail I believe I'd still be in school and stuff like that I don't believe I'd have tattoos You know, I probably would have been better off, but I'm happy Right now, I'm happy Just me, Carol and my baby"

On that particular day, Michael was slouched on the living room couch at the home of Beverly Read's mother Next to him sat his wife, Carol, a pretty 16-year-old with long brown hair and freckles It was early in the morning, and Carol was drinking a Coke and eating sour cream potato chips, in between cigarettes

Carol also spent time in foster care, although unlike Michael, she was raised most of her life by her mother, not the state Both her parents have been in jail, her father for killing a man The last time Carol saw him was when she visited Michael in jail last summer According to Carol, Michael was there for driving without a license

"My husband and my father — both in jail" she mused

Trouble is in Michael's and Carol's blood, and like recovering alcoholics, they have to work one day at a time to stay away from it Michael's been arrested at least five times since becoming an adult at 18

"What got me in trouble was people I hung around with," Michael said

Both Michael and Carol dropped out of high school in the eighth grade Michael has worked periodically, but he can't legally drive The couple would like to live together with their baby, but can't afford an apartment So Carol lives with her mother, and when he's not in jail Michael lives with his, a woman who spends most of the day in bed, according to her son

"Michael seems to think that you have to have it all to be productive — the decent job, the home for your family," Mrs Read says "And he gets discouraged, because he can't grasp it all at the same time He wants it so bad, but it's out of his reach"

Special

Carol Harmon in the hospital after the birth of the Harmons' second son, Joshua, who remains in his mother's custody.

Carol's mother would like to keep her daughter away from Michael Almost two years ago, when Carol was pregnant with Michael's first child, her mother put her in the custody of the Clayton County Department of Family and Children Services after Carol repeatedly skipped school and refused to stay away from Michael Two days before her baby was due, Carol was placed in foster care

She says social workers talked her into giving her baby up for adoption She says they told her if she didn't, she and her baby would be placed in separate foster homes So she agreed, and under the effects of Demerol less than 24 hours after giving birth by Caesarean section to a baby boy, Carol signed a release abdicating her rights as the mother

Under Georgia law she had 10 days to change her mind While she was in the hospital, Michael rode a bicycle more than 15 miles from Grant Park to Clayton County to see Carol and the baby He'd been told if he didn't stay away from Carol, he'd go to jail He never did see his baby

Carol went directly from the hospital back into the foster home She says she told her foster mother during the 10-day period that she'd changed her mind She wanted her baby back But the law says that has to be in writing Carol can barely read

Carol had named Michael as the father, and the county wrote him a letter, informing him that his child was being placed for adoption and it was imperative that he contact them within five days

Michael appeared at the Clayton County office on the fifth day Officials acknowledge that Michael was "adamant" about wanting to keep his baby and asked them how he could prevent the adoption He was told he needed to hire a lawyer to "legitimate" the child, then file for custody

Michael eventually got enough money to hire a lawyer, married Carol and went to court last July to fight to get their baby back, but their parental rights were terminated The reasons She had voluntarily surrendered her rights, he had shown "no interest" in the child and had failed to make any attempts to "legitimate" his baby

The couple's "youth and inexperience" were also mentioned And finally officials with the Clayton County Department of Family and Children Services — the agency that had raised Michael — made mention of the fact that he and his wife came from an unstable background and "have in fact been raised in several foster homes"

In courts around the country, parental rights are generally terminated only after it has been shown that a child cannot safely return home Although one of the five indicators for such a situation is "extreme parental disinterest," traditionally the courts have terminated rights on this basis only in cases where parents have abandoned their children

'Thousands of Michaels'

Mrs Read was outraged, calling it another example of how the foster care system had victimized Michael In a scathing letter that was published in The Clayton Sun, she traced Michael's life

"Now this former bitter and distrustful child is a bitter and distrustful adult," she wrote, "as beaten down and sad-eyed as any abandoned animal Where are the people to fight for his cause? Just as we have citizens willing to fight for our abandoned and helpless animals in our county, we need citizens to fight for our abandoned and helpless children in our county Many of these children are more in danger of being abused or 'abandoned' by the system of the Department of Family and Children Services, Juvenile Court, etc., than if left to their own devices"

In a recent interview, Anne T Plant, director of the Clayton County Department of Family and Children Services, agreed that children like Michael are sometimes further victimized by the state's foster care system

"There are thousands of Michaels

LONGING Continued on **Page 26**

Longing

From Page 25

out there," she said "Their own mothers and daddies don't want them How do we expect anyone else to? Unfortunately, they'll be the ones who will be punished later on, rather than the people who did it to them"

In part because of their victimization, she said, Michael and Carol's child is better off with a more stable family "Here we go with a couple that probably can't take care of this child, not because of their unwillingness, but because they're victims So they raise that child, and that child becomes a victim There's no solution"

Michael and Carol didn't know they could appeal the court's ruling in Clayton County Even if they had known, they don't have the money to hire another lawyer

Today their first-born is described as a plump, brown-eyed child with brown hair and a double chin "He's such a happy fella," a county social worker has said "His smile is so big it covers most of his face He is a delight to behold

Michael and Carol had talked about naming him Joshua Michael has never seen him "He's supposed to be adopted right now," he said "I can deal with that, you know I mean he's already gone and everything If he's adopted out, I can deal with that but I don't want him to be in no foster homes for the rest of his life"

Yet almost two years after his birth the child remains in foster care County officials say they are investigating the possibility of placing the child with one of Michael's relatives But it is a lengthy process

Each day that passes puts the baby at greater risk of remaining forever in foster care People want to adopt babies, particularly white ones Few want to adopt children

"It hurts me pretty bad that my son is in there, you know," Michael said "I think about it every day"

Last October, Michael and Carol had a second son His name is Joshua According to Mrs Read, they have been taking good care of him — keeping up with his immunizations "There is goodness in him," she says of Michael "And there is a desperate need in him to someday succeed, to someday make it"

As Michael sat last winter cradling his newborn son, he made a simple pledge "I won't let my son live the kind of life I do," he said "My son always has some place to go"

For now, Michael not only can't afford to go back to school, he's afraid to If he doesn't earn enough money to feed his baby, he's afraid the county will take him away too "I'm not going to give them people a chance to even say I'm doing something wrong," he said

As he spoke, his baby cooed "I believe I can make it if nobody messes with me," he said "I just want to be happy I want to get my own place and work every day like normal people And be happy"

Just Michael and Carol and their baby

(Postscript On May 9, Michael Steven Harmon pleaded guilty to two separate charges for breaking into a house and breaking into a man's Volkswagen He was sentenced to serve two years in prison and the remainder of a five-year sentence on probation Last Wednesday Michael was transferred from the Clayton County Jail in Lovejoy to the Georgia Industrial Institute at Alto where he will remain for the duration of his prison term Carol is still caring for Joshua)

Foster Care Population Keeps Growing

In 1980, the federal government passed legislation aimed at reducing the number of children in foster care Despite aggressive efforts to comply with the law, Georgia's foster care population rose nearly 45 percent between 1984 and 1988

The reasons

- Abuse and neglect In Georgia, reports of child abuse and neglect jumped to 39,100 in 1987, a 26 percent increase from the year before
- Urban housing crisis In metropolitan Atlanta, as many as 3,000 children are counted among the city's homeless, and the number is growing, according to Anita L. Beaty, executive director of the Task Force for the Homeless
- Teenage pregnancy Georgia has the highest teenage pregnancy rate in the South, with more than 11,000 teenage births in 1987

And the more recent specters of

- Drugs, particularly the highly addictive cocaine and its derivative, crack At Grady Memorial Hospital, the state's largest public hospital, the number of drug-addicted babies has skyrocketed, with more than 200 babies a month now showing positive signs of drug addiction, mostly to cocaine
- AIDS Georgia ranks 11th in the nation in the number of AIDS-infected children Currently, Grady is following more than 100 babies who have been exposed to the disease and may or may not get full-blown AIDS Many were born to drug-addicted parents whose needle sharing led to their own infection of the disease

Among the results

- As of May 15, 6,200 children were in foster homes in Georgia, but the state had only 3,000 foster homes to take care of them Another 525 children were in foster care institutions
- Seventy-six percent of the children in foster care in Georgia were placed there because they had been abused, neglected or abandoned by the people responsible for their care Another 15 percent were placed there because their parents were in jail, mentally ill or addicted to drugs The rest were put there for such varied reasons as awaiting adoption, being without guardians after the death of parents, or needing supervision that parents no longer could give them
- The median length of time children remain in foster care is 30.8 months
- The average age of children in foster care in Georgia is 10
- Seventy-five percent of the children leaving foster care are returned to their parents or guardians Another 15 percent are placed with other relatives Approximately 20 percent of the children who are returned to their parents are back in foster care within a year

A Foster Squeeze

The number of children in Georgia's foster homes increased by 44.6 percent in the last five years, while the number of foster homes increased by only 14.5 percent.

Year	Children	Homes
1984	4,446	2,500
1985	5,375	2,588
1986	5,440	2,621
1987	5,880	2,696
1988	6,430	2,863

Source: Georgia Department of Human Resources

Three cases of frustration, anger

Baby Returned to Parents — and Killed

By Jane O. Hansen
Staff Writer

Among Beverly Read's family photos is a picture of two little boys sitting on the lap of Santa Claus. It was Christmas 1982 when Bobby Hendrick, barely a year old, was safe and happy in the Jonesboro foster home of Mrs. Read and her family. Less than two years later he was dead.

Although it has been five years since Bobby's death, Mrs. Read and her husband have not forgotten the little boy with the large brown eyes and "deep, throaty laugh."

"He was just a real bubbly, responsive baby," Mrs. Read recently recalled, adding that he was forever taking off his clothes. "Diapers, everything," she laughed.

Nor have they forgiven the child welfare department, which they blame for the child's death.

For six months, Bobby and his 2-year-old brother had lived with the Reads, placed there by the Clayton County Department of Family and Children Services after their father, James C. Hendrick, had voluntarily put them in foster care.

Mrs. Read says today that she warned caseworkers not to return the boys to their father until they had thoroughly investigated Hendrick's home. But caseworkers took the children anyway, assuring her they would keep a close eye on Bobby and his brother.

Several months later, the children were taken by their father and stepmother, Debbie C. Hendrick, to the local health department, where staff members noticed that the little boys' bodies were covered with sores and bruises; their heads had only patches of hair.

They called the child welfare department, and Phil Woodward, a caseworker, was dispatched to the Hendricks' trailer home.

Mr. Woodward would testify later — during the murder trial of Bobby's parents — that he considered the couple cooperative, found nothing unusual at the home, and subsequently "closed his notes" on the matter.

During the trial, Bobby's parents, both 23, were described by the defense attorney as "two young kids trying their darndest to make ends meet and raise three kids — an awesome responsibility." But a police officer testified that according to Debbie Hendrick's 4-year-old daughter, it was not unusual for Hendrick to pick up his baby boy and smash him against the wall.

Doctors say that when his stepmother brought him to Clayton General Hospital in the early hours of Feb. 8, 1984, Bobby's skull was cracked from the top left side of his head around to his neck cavity in back. Mrs. Hendrick told physicians Bobby had fallen out of bed.

In addition to his fractured skull, physicians noticed the toddler was covered with bruises, appeared malnourished, was missing large clumps of hair and had a misshapen arm. In all, they found 25 injuries. Among them, the doctors discovered that both of Bobby's arms were broken. They had been that way for at least three weeks, left unattended despite what the doctors said would have been the baby's obvious pain. He was pronounced dead on Feb. 10, 1984.

A year later, the Hendricks were each convicted of murder and sentenced to life in prison. They will be eligible for parole consideration in three years.

Within weeks of Bobby's death, Mrs. Read wrote a series of angry letters, including one to Attorney General Michael J. Bowers, asking him to investigate the county child welfare agency. She would later take the stand at the Hendricks' murder trial and criticize the department for failing to protect Bobby.

Shortly after the trial, the Reads' only remaining foster child was returned to her natural mother. After six years of having cared for more than 30 foster children and even adopting a child, the Reads have not been given another foster child since.

"Beverly Read is a very caring person," Anne T. Plant, director of the Clayton Department of Family and Children Services, recently said. "She just will not accept this agency as the legal authority in these situations."

Special

A snapshot shows foster mother Beverly Read with Bobby Hendrick (left) and his brother. Bobby was later murdered by his father and stepmother.

Private Eye Hired To Fill the State's Shoes

By Jane O. Hansen
Staff Writer

In the South Georgia community of Tifton, Harry Doss is the quiet, respected county director of roads and public works. He predicts that perception could soon change.

For five years, the Dosses — parents of two grown children and a 15-year-old son — have been accepting foster children into their home. Now they've hired a private detective to help protect one of those children, something they say they've been forced to do because of the local child welfare agency's failure to do its job.

The focus of their efforts is a little girl who was abandoned by her parents when she was 2 and brought to the Dosses' home on July 4, 1987, by the Tift County Department of Family and Children Services.

"She was the dirtiest child I'd ever seen in my life," Charlotte Doss recently recalled of the red-haired toddler. "I bathed her three times that afternoon."

The couple felt the little girl was underweight for her age, and when they took her to the pediatrician for a physical, the doctor wrote in his records that he suspected that the lesions on her buttocks were cigarette burns.

"She was absolutely terrified of men," Mrs. Doss said. "My husband couldn't pick her up. And she had these godawful nightmares."

Their concerns grew after the department found the child's natural father, Walter F. Byrd, and began staging visits between the two. After one visit, as they changed her diaper, the Dosses noticed abrasions on her inner thighs and a small tear between her anus and vagina. They also felt the child was using inappropriate sexual terminology for her age.

According to an affidavit the Dosses would give to a Superior Court judge, she cried continuously after one visit, patting her diaper in front and saying, "hurts — right here."

Finally, to convince the caseworker that their fears were justified, Mrs. Doss says she staged a "before and after" diaper change in the caseworker's presence. Before the visit, the little girl had no vaginal tear. After the visit she did, according to the affidavit. The caseworker suggested the tear may have occurred while the child's father was straddling her on his knee.

They registered their final complaint Oct. 17, 1988, after a weekend visit at the home of the little girl's paternal grandparents, where her father also lived. Shortly afterward, the child welfare department notified them that the child was being removed from their home and returned to her paternal grandparents.

The Dosses were stunned and promptly wrote a letter to Rodney Griffin, director of the county Department of Family and Children Services. They pointed out that only a year earlier, Mr. Byrd had been charged with the felony of abusing his daughter. That charge is still pending, according to Tift County District Attorney David E. Perry.

"They had this father arrested for cruelty to this child and now they've gone and put her back in the home," Mrs. Doss said.

What particularly angers the Dosses is that a Superior Court judge in neighboring Cook County had a year earlier found the man an unfit parent for his two older children, based on the alleged abuse of his younger child.

Mr. Griffin of the local child welfare agency recently defended his caseworkers' decision to return the little girl to her grandparents' home. "This was not a decision we arrived at overnight," he said. "It was arrived at after careful study."

He described the grandparents as "a very good, loving couple" who are financially well-off and well-respected in the community.

"It's our policy and philosophy to always try and keep children in some part of their extended family if placement with the natural parent is not possible," he said. "We worked very hard to try to minimize the disruptions in this child's life."

Based in part on the Dosses' complaint, however, a Juvenile Court judge has ordered that Mr. Byrd move out of his parents' home. The Dosses have hired a detective to make sure he does.

The court also granted Mr. Byrd visitation privileges, but ordered that the visits with his daughter be supervised by his parents. "They love their son," Mr. Griffin said of the grandparents. "But they understand they must protect their granddaughter, and they will be very good at doing that."

JOHNNY CRAWFORD/Staff

Harry Doss carries lumber to be cut into pieces for two foster children, who will use the wood for a school project. The Dosses have hired a detective to try to protect another foster child removed from their care.

Children Sheltered — But Never for Long

By Jane O. Hansen
Staff Writer

David Doss of Rome never wanted to be the one who sued the child welfare agency, but he could find no one else to do it.

"I said at the time, if I never do anything else in my life, I'm going to do everything I can to make sure this doesn't happen to another child," he said.

What happened in Floyd County, says Mr. Doss, is beyond his comprehension. Mr. Doss is not a foster parent. Rather he's a Floyd County commissioner who sells real estate for a living and happens to be on the board of the Open Door Home, a temporary emergency shelter for abused and neglected children.

It was in this capacity that two years ago he met a family of four children — ages 5, 3, 2 and 6 months. Mr. Doss would later learn that the Floyd County Department of Family and Children Services had removed the children from their home 11 times, usually substantiating abuse and neglect reports before returning them to their mother.

"That's an awful lot of times," Mr. Doss said. "At some point, you'd think the light bulb would have turned on in some caseworker's head and they would have said, 'Look, the situation's not going to get any better.'"

The last time the children came through the shelter, Mr. Doss said, they were so filthy that shelter staff had to throw their clothes into the dumpster. When they took them for a routine physical, the doctor extracted a decayed cockroach from the ear of the 2-year-old boy, who had been complaining of an earache.

That time, a Juvenile Court judge ordered the child welfare department not to return the children to their mother until she found a suitable living arrangement. At times the children had slept in a car.

Despite the court order, the caseworker appeared one day at the Open Door Home and announced she was returning the children to their mother. "I made the comment to the shelter director that if something happens to one of those kids, and they're not where they're supposed to be, the state's butt is going to be in a sling," Mr. Doss said.

In less than 10 days — on March 25, 1987 — the mother appeared at the Floyd Medical Center with her 3-year-old daughter, who was bleeding from her vagina.

JOHNNY CRAWFORD/Staff

Floyd Commissioner S. David Doss has sued the child welfare department for alleged 'gross negligence.'

"The mother said she had fallen and hurt her bottom," Mr. Doss said.

But doctors felt the story was inconsistent with the injuries. In part because the child would not let them touch her, they suspected she had been sexually molested and called child welfare. A caseworker came to the hospital, heard the physician's suspicions and returned the child that day to her mother.

Two days later, the mother brought the child back into the emergency room. She was still bleeding, and this time, after he anesthetized her, Dr. Jack Rogers discovered genital warts and a laceration at the opening of her vagina. He admitted her to the hospital for her own safety.

"Based on my examination and on the reports to me from my consultant, I feel that it is medically certain this child has been subjected to repeated sexual abuse," Dr. Rogers wrote in a letter to the child welfare agency. "I am available to testify to these findings in court."

The letter sat at the Department of Family and Children Services office for more than a week before caseworker Mignon Price took it to the police. The delay "outraged the detectives," said Mr. Doss. "The case is now nine or 10 days old."

According to Mr. Doss, police officers never did find enough evidence to file criminal charges against anyone. The four children are now in foster care.

"This whole thing just outraged me," said Mr. Doss. "I couldn't believe they would continue to put these kids at risk after repeated, substantiated cases of abuse and neglect."

In the months ahead, he went before three grand juries, finally urging jurors to subpoena the case file and get a firsthand account of "the circus of how this child has been treated." "When they got the file, only then did they get behind the smokescreen," he said.

The final grand jury called for a state investigation, which was conducted by the Carl Vinson Institute of Government at the University of Georgia. The institute's report, according to Mr. Doss, "basically said child protective services was in complete disarray, that caseworkers had little or no training and were delivering below minimally acceptable standards of care, that they continue to put kids at risk and morale is low."

As a result of that report, a number of child welfare officials in the county and regional offices were demoted, transferred or encouraged to take early retirement. Ms. Price, whom Mr. Doss had hoped to have indicted on charges of interfering with a criminal prosecution, was promoted to senior caseworker.

Ms. Price said recently that she could not comment on the case and referred questions to Jim Burton, now the county director. He, too, refused to comment.

Dr. Rogers said in general he has found Ms. Price and her colleagues to be "very, very helpful" in "case after case." But he also said that lawsuits such as Mr. Doss's serve a purpose by drawing attention to the problem.

"Child abuse is the most dangerous disease I see," he said. "We see more deaths from child abuse than meningitis. . . ."

Ultimately Mr. Doss blames the fiscal bottom line for the state's readiness to return children to violent homes. It costs nothing to send a child home, but the state picks up the tab for children in foster care.

"So the state says, you keep them at home," he said. "And that's why you get these horror stories."

In April, after failing to convince anyone else to do it, he filed suit, accusing officials of the Department of Family and Children Services of "gross negligence." The suit seeks unspecified damages to be placed in a trust fund for the girl. Mr. Doss says he had no choice; he has a baby daughter of his own. "Every time I looked into that little girl's eyes, I saw my own kid," he said. "It just wasn't anything I was going to drop."

Children Often Wait 'Their Turn' At Having Real Home

SUFFER THE CHILDREN

PART 5

By Jane O. Hansen
Staff Writer

One week after Michael was born, his mother signed papers giving him up for adoption. At the time, Michael was considered a normal, healthy black infant — the kind of baby a waiting list of families would have been eager to adopt if the Clarke County child welfare agency had done its job.

It didn't. Rather it placed Michael in foster care and virtually forgot about him.

Last year, a caseworker rediscovered Michael and took steps to find him a permanent home. But it was too late. After six years in foster care, Michael is now considered mentally retarded, can barely speak and is struggling to learn sign language. Today there is no family waiting to adopt him.

Michael is one of the victims of a state adoption process plagued by bureaucratic inertia and too few resources to match the children with the families who want them.

"The system is not working. Children are just sitting," said Kathryn H. Karp, whose catalog of children with special needs — called "My Turn Now" — is one of the most successful tools in Georgia for recruiting adoptive parents. "Most of the children who come into the state's care and need families are failed by the system. They could be placed in new families and be on with their lives, and they're not."

On any given day in Georgia, there are close to 500 children in the state's custody who are available for adoption — most because they were so severely abused or neglected by their parents that parental rights have been severed.

Unlike the healthy white infants who are in top demand, almost all the state's adoptable children have special needs — meaning they are black children over 1 year, white children over 8, children with mental, physical or emotional handicaps, or children with brothers and sisters whom the state wants to place as a group.

Despite the children's special needs, a growing number of adults want to adopt them — older adults who are starting their families later in life or couples and single adults who can't afford to privately adopt an infant but still want children.

Yet families have waited three or four years before the state places a child with them. Some give up in frustration. Others, such as Dr. Lytia Howard, are forced to go out of state.

Several years ago, Dr. Howard told the Fulton County Department of Family and Children Services that she was interested in adopting two older black boys — children who are readily available and among the hardest to place.

After choosing a pair of brothers in the "My Turn Now" book, she was told she couldn't have them. The boys needed a father, caseworkers said, and she was single.

When she was turned down again on another set of children she had identified, she turned to other states. Within months, she was approved by Pennsylvania's child welfare agency to adopt the two children she has today — Richard, 8, and Ryan, 6.

"If there are over 400 children in Georgia who need homes, then you tell me why it takes over two and a half years to process an adoption," said Dr. Howard, director of special programs for Georgia Tech's College of Engineering.

No 'Efficient System' for Placement

Ms. Karp, whose agency is private but receives its space and some funding from the state, attributes the delays to shoddy management and a lack of resources. Despite the waiting list of nearly 500 children, there are only three people in the state department's central office to manually sift through all the families on file and find a match for each individual child. According to Ms. Karp, the state has made efforts to computerize the system for six years, but it is still not up and running.

According to Geraldine Jackson-White, chief of the state's adoption unit from 1982 to 1986, stories such as Michael's are all too common.

"I guess the pressing problem that's facing the adoption program now is we have children who are free, who have remained free for a long time, but there's not an efficient system for recruiting families, studying them and placing the children," she said.

Jimmy, who has Down's syndrome, was available for adoption at birth, but a Richmond County caseworker assumed no one would want the mentally retarded baby.

That assumption helped keep Jimmy out of the adoption pool for eight years. When the county child welfare department finally did publicize Jimmy's case recently, it took only two months before a family from Michigan stepped forward in hopes of adopting the child.

But it may be too late. At 9 years of age, Jimmy cannot speak, he's not toilet-trained, he's barely learned to walk. Although the Michigan family has other Down's syndrome children, the parents did not feel they could handle Jimmy's unique problems. He's still waiting for a family he can call his own.

Ms. Jackson-White blames the state's legislators for failing to make children the priority they deserve to be. An increase in funding and staff would go a long way toward finding hundreds of children permanent homes, she says.

"The Department of Family and Children Services always takes the blame," she said. "But they are as constrained as the General Assembly makes them. Everybody thinks children are being taken care of, and they're not."

Forrest B. Burson, the state's current head of adoption, says the situation is not nearly as bad as these women suggest. "We've made so many changes and come so far," he said.

For one thing, Mr. Burson says, the numbers are misleading. Rather than 500 children up for adoption — a number quoted not only by Ms. Karp, but also by the national Child Welfare League of America and the department's own public relations office — Mr. Burson says a more accurate tally is about half that. Adoptive homes have

JOHNNY CRAWFORD/Staff

Richard Wright reads the newspaper while his wife, Joyce, helps daughter Edna with homework and daughter Lora works at the table. The Wrights adopted four sisters.

been identified for all but 253 children, he says. Legal proceedings have just not been completed.

And while a recent national study by the Child Welfare League shows there are more than 2,000 Georgia couples waiting to adopt a child — the third highest number in the country — Mr. Burson says these are people who want a healthy white infant, what he calls an "adoption fantasy."

"We just don't have healthy white infants available for adoption in public agencies," he said.

Only 170 families are waiting for special needs children, according to Mr. Burson. Still, even those families wait, sometimes for years before the agency gets around to doing a home study on them.

"I just don't believe that there's a real commitment to placing children, be they younger or older," said Paula E. Bonds of Atlanta, who adopted a child from Illinois after becoming frustrated in her attempts to get an older black child from Georgia. Ms. Bonds is regional counsel for the NAACP.

Some parents are forced to wait because the children available aren't the ones they want, according to Mr. Burson. "Not all the families and not all the children will match up," he said. "A lot of the families say they want special needs children, but when it gets down to telling them what the specific needs are, they say, 'I don't know if I can handle that.'"

The primary delay, however, has resulted from the way the state traditionally has conducted home studies, Mr. Burson said. He says a new method for making the evaluations, now being phased in across the state, should alleviate the problem soon.

Homes, Shelters — Finally a Family

Another bright spot is the success of the "My Turn Now" catalog and WXIA-TV's "Wednesday's Child." Both feature children who want and need homes. Thanks to both programs, a few get lucky and find homes. They're children like Angie.

At 6, Angie was so neglected by her mother that she and her sister and brothers were removed from their home and placed in foster care.

Angie was 9 when the Bartow County Department of Family and Children Services finally moved to terminate her mother's parental rights, freeing the children for adoption.

For a total of six years, Angie was shuttled between a half-dozen foster homes, staying in between placements at an emergency shelter in Rome.

She was in the process of being adopted by one of her foster families when authorities discovered her foster father had been sexually abusing Angie, perhaps for the entire two years she lived there.

In the ensuing months, the state sent Angie's picture to Ms. Karp to be listed in the "My Turn Now" catalog. When Mike Dobbins and his wife, Jane, first saw Angie's picture and expressed an interest in adopting her, they were told that both she and her sister were tied up as witnesses in a child sex abuse case and were unavailable for adoption.

The couple persisted, and in March 1987 Angie moved into the family's Adairsville home. On Feb. 12, 1988, she became Angie Dobbins. She was 12 years old.

WAIT Continued on **Page 32**

Wait

From Page 31

Because of her mother's neglect, Angie's teeth had deteriorated so badly that she had difficulty speaking, a handicap that had put her behind in school.

"When she moved in with us, she couldn't add 2 plus 2 without counting up on her fingers," Mr. Dobbins said.

In the "My Turn Now" catalog, Angie was described as "mildly mentally retarded."

Immediately the couple bought a set of flashcards and began working with their daughter each evening. At the end of the school year, Angie brought home a report card with three A's, two B's and a C. The family celebrated at a nearby restaurant.

"It changed her whole attitude about school," Mr. Dobbins said.

Today at 14, Angie is an active girl with hazel eyes, curly brown hair and a penchant for roller skating.

But her life could have started a lot sooner, her father says. From the time Angie and her sister and brothers were first placed in foster care, three years elapsed before their mother was finally given an ultimatum to give up her parental rights voluntarily or face the child welfare agency in court.

For Angie's older sister, the damage by then had been done. Today the 15-year-old remains in foster care after spending nearly a year in a psychiatric hospital.

One of the most pressing problems contributing to the further abuse of children once they enter the child welfare system has been the amount of time it takes to terminate parental rights, according to a growing number of adoptive parents.

An 'Instant Mom'

"We need to set a limit on how long we're going to try to keep a family together," said Joyce Wright of Atlanta, a business analyst for Southern Company Services and the adoptive mother of four girls. "I think we place too much emphasis on the natural parents. If they don't shape up in a year, I think we should take those children then."

Life for her daughters was a Charles Dickens tale before Mrs. Wright and her husband, Richard, invited them to become permanent members of their family.

Their father had died when they were young, leaving the girls and their four older sisters with a mother who was neither capable nor desirous of caring for them.

Initially, the oldest sister tried to raise them, but after a few weeks, she decided their care was too much to handle.

For five years, the children lived in an isolated group home in Toccoa. There they were under the tutelage of a fundamentalist Baptist preacher who believed in strict corporal punishment and provided them with no formal education. When their mother filed a petition in court one day to get her children back, the state welfare agency discovered their living conditions and took custody of them. For the first time, the children were split apart and placed in separate foster homes.

"I think it had a tremendous impact on them," Mrs. Wright said. "It became their goal to get back together."

While home for lunch one day, Mr. Wright saw the girls featured on Channel 11's "Wednesday's Child" program. Both Mr. and Mrs. Wright were on their second marriages but eager for children. Recently they had begun talking about adopting a child or two.

"He called me at the office and was real excited and said, 'I just saw some kids that I think you should see,'" Mrs. Wright recalled.

In May 1987, they contacted the DeKalb County Department of Family and Children Services and began the lengthy process of adoption. By the time the girls moved in, Patricia was 16, Penny 12, and Edna and Lora, the twins, 10.

"It was a real experience for me," Mrs. Wright said. "I went from no children to four children. Instant mom."

But she and her husband say the adjustment for their children was far greater. Their years in the Toccoa home had slowed them down enormously both academically and emotionally, their mother says.

"They were so secluded that they had really limited experiences and big gaps in just life in general," she said.

When she sent them into McDonald's with permission to get whatever they wanted, "they didn't know how to do that," she said. "They'd never been to a restaurant."

Patricia has had the hardest time adjusting. For years, she had served as the children's mother, a role all four girls found difficult to give up. Although a pretty girl, today Patricia keeps to herself and has trouble making friends.

"You never hear her sitting around giggling on the phone," her mother said. "She's not into clothes. Sometimes I'll tell her go on and be a teenager. Most of the children her age are carefree and she is not carefree. Probably never has been."

Because of the special needs of children such as these, families can receive up to $228 a month in government funds for each adopted child. Some children also qualify for Medicaid coverage.

The "My Turn Now" book is full of children such as the Wrights', who despite their near-adult status do not want to face adulthood alone.

"It's hard for a person that old to decide they want to be adopted," Mrs. Wright said. "But Patricia very much wanted to be adopted before she was 18. I guess she wanted to establish her roots before she came of age."

Georgia Adoption Agencies

If you are interested in adopting a "special needs" child, you can contact your local Department of Family and Children Services or call My Turn Now in Atlanta at 894-3748. Other avenues for adoption include the following private agencies:

Metro Atlanta

Catholic Social Services Inc. 881-6571

Christian Homes for Children Inc. 425-8433

Families First 873-6916

Friends of Children Inc. 256-2121

Georgia AGAPE Inc. 432-0063

Georgia Baptist Children's Homes and Family Ministries 463-3344

Homes for Children International Inc. 897-1766

Illien Adoptions International 872-6787

Jewish Family Services Inc. 873-2277

LDS Social Services 939-2121

Lutheran Ministries of Georgia 875-0201

Central Georgia

Bethany Christian Services, Macon 912/742-6964

Georgia Baptist Children's Homes and Family Ministries, Meansville 404/567-8987

The New Beginning Adoption & Counseling Agency, Columbus 404/561-7954

East Georgia

Family Counseling Center, CSRA Inc., Augusta 404/738-9750

Southeast Georgia

Parent and Child Development Services, Savannah 912/232-2390

Southwest Georgia

Adoption Services Inc., Pavo 912/859-2654

Open Door Adoption Agency Inc., Thomasville 912/228-6339

> 'We need to set a limit on how long we're going to try to keep a family together. I think we place too much emphasis on the natural parents. If they don't shape up in a year, I think we should take those children then.'
>
> **— Joyce Wright**
> **Adoptive mother of four girls**

One 16-year-old currently profiled in "My Turn Now" is a boy named Stoney. A "caring young man with sparkling blue eyes. Stoney has no major health problems, nor physical limitations," the book says. "He is depressed, though, about his life situation and the fact that he is in foster care. It is felt that Stoney would be much less depressed if he had some stability and permanence in his life." (Recently a family has expressed interest in adopting Stoney.)

'Ours Is a Positive Story'

The book itself is a sad commentary on the needs of hundreds of Georgia children. Even Ms. Karp finds the catalog a bit offensive.

"It's like going shopping for a child," she said. "But you can't beat success, and if that's what it takes to place these children, you have to do it."

Some children don't understand why no one offers to adopt them once they're advertised. Eddie, 12, and his brother, Trekaris, 8, are described as "delightful, engaging and outgoing youngsters. They both love bike riding and are interested in participating in sports. They are very attached to each other and are in need of a placement together. They are looking forward to being adopted."

After three years of being profiled, they recently asked to be removed from the book. According to Ms. Karp, "The older one finally said, 'I will no longer have my picture taken. I will no longer go on TV. What's wrong with us?" (Since then, a family has expressed interest in adopting them.)

Ms. Karp and Mr. Burson agree that if more families were exposed to these children, they might realize there was a place for them in their homes.

Since moving in with the Wrights, Patricia and her sisters have made steady progress both at home and at school, where the two older girls have particularly had problems.

"Ours is a positive story," Mrs. Wright said. "And it's the kind of story I think people need to hear. There are lots of kids that people could work into their lives, but they're afraid. And I understand that. I'd just like to be able to dispel some of their fears. The truth is, our lives have been enriched by these girls."

Michael

Eddie and Trekaris

Jimmy

Children from the 'My Turn' Book

- Michael was considered normal and healthy when his mother surrendered him for adoption when he was 1 week old. But the Clarke County child welfare agency instead put him in various foster homes, where he was virtually forgotten for six years. Michael is considered mentally retarded and is barely able to talk.

- Eddie and Trekaris, outgoing brothers who like sports, spent three years hoping someone would see their picture in "My Turn Now" and adopt them. Finally, Eddie decided that he and his brother would no longer be photographed for the book, wondering in exasperation, "What's wrong with us?" (Since then, a family has expressed interest in adopting them.)

- Jimmy, who has Down's syndrome, was available for adoption at birth, but a Richmond County caseworker assumed no one would want the mentally retarded baby. After eight years in foster care, Jimmy's chances for adoption have dwindled. A Michigan couple recently offered to adopt him, then changed their minds, deciding he had too many problems for them to handle.

Sexual Molestation Trial Pits 6-Year-Old Against Stepfather

By Jane O. Hansen
Staff Writer

SUFFER THE CHILDREN

PART 6

The morning 6-year-old Matthew was scheduled to testify against his stepfather, he tried to comfort himself with "angel cards."

The cards were a device he and his 33-year-old mother, Judy E. Hanson, had been using to prepare him for court. As he stood by his mother in the living room, the little boy — a tiny child for his age with large brown eyes — shuffled through the cards, each depicting a virtue such as truth, honesty, courage and justice.

"It was really sad," his mother said recently. "He was very upset."

The little boy later took the stand and did a lousy job of telling the jury what his stepfather had allegedly done to him. According to Matthew and his mother, Ronald Chafin of Jonesboro had repeatedly sexually molested him — anally raping the child and periodically putting sticks, beer bottles and his adult hand in the little boy's anus.

Tapes of the 1988 trial reveal that in front of the judge and jury, the child was nervous and distracted and, when asked about bottles and anal sex, whispered his response. After three days of testimony, the judge directed a verdict of not guilty.

Mr. Chafin calls the allegations absurd and says his former wife brainwashed her child. Despite his acquittal, he says today that he has been permanently scarred by the charges.

"I can't be damaged any more than I already have been," he said recently. "It was scary. You can't believe it's happening to you. One morning you're married with a wife and kid, and the next thing you know this is happening."

But the case of Matthew goes beyond the separation of fact from fiction in the face of sexual abuse allegations. It offers an inside view of the trauma that often permeates a courtroom in such cases. Perhaps more than anything, Matthew's story underscores the court's insensitivity to child witnesses.

During the trial, Matthew was seated directly facing Mr. Chafin. His psychologist, Dr. Barrie Alexander — an expert in child molestation — was not allowed to tell the court what the little boy had told her, despite a recently passed state law that permits such testimony. His mother's testimony was also limited.

The verdict was directed by Judge Joe C. Crumbley, chief judge of the Clayton County Superior Court, who told the jury the state had failed to prove venue "beyond a reasonable doubt." In court parlance, that means Assistant District Attorney Daniel J. Cahill had failed to show that the alleged crime had been committed in Clayton County.

But under the law, "slight evidence of venue is all you need," Mr. Cahill said recently. "I thought that was the least of my worries in that case."

Today, some jurors say they were stunned by the judge's abrupt decision to end the trial.

"I was very disturbed when he brought us back into the courtroom and said there was no case," said Phillip C. Bohan, a regional director for Eastern Airlines. "I was appalled."

Even if the judge had not directed a verdict of not guilty, Mr. Cahill says the state's case was weakened by the judge's refusal to allow most hearsay evidence, even though the prosecutor and others contend state law permits such testimony.

Recognizing children's limitations, the Georgia Legislature passed a general hearsay exception for children in 1986. That exception allows the testimony of people to whom a child may have disclosed abuse — people such as Dr. Alexander, a licensed psychologist who has treated several hundred sexually abused children in the last six years.

She had begun seeing Matthew in June 1987 and continued seeing him up to the trial in April 1988. But jurors would hear very little from Dr. Alexander that day in Clayton County Superior Court. Nor would they get a full report from the Grady Memorial Hospital pediatrics resident who had examined the boy.

"It was definitely the worst experience I've ever had as an expert witness in the courtroom," Dr. Alexander recently said.

Judge Crumbley said the admission of hearsay would have been a violation of state law. "Georgia law basically says that the hearsay exception can only come in if the child is available on cross-examination," he recently said.

The child not only was available, he testified twice. "He has to be available for meaningful cross-examination," the judge said. "This child could not talk."

Clash of Mother, Stepfather

Before she married Mr. Chafin, Judy Hanson had been married and divorced twice. Matthew's father was a man she'd had an affair with. They were never married.

In court, J. Dunham McAllister, her husband's attorney, would ask her if she'd ever used a vibrator for sexual gratification. Did she presently own one? When did she last have one? The questions had the intended effect.

"I don't guess it had anything to do with it, but it sure didn't look good," said John H. Roseberry, a juror.

Ms. Hanson is a small, thin, articulate woman with the dark hair of her son. A registered nurse who often works with terminally ill patients, Ms. Hanson describes herself as overly trusting.

Her former husband calls her "selfish" and "crazy" — "a paranoid schizophrenic and a sociopath." "Until somebody stops her, she's going to ruin more lives," he said.

In high school, she had chased Ronnie Chafin, a success-oriented, intelligent young man who sometimes arranged free band concerts at nursing homes. They married more than a decade later, just after Matthew had celebrated his second birthday.

Ms. Hanson says she became concerned about her 4-year-old son in October 1986 when he walked into their bathroom in Clayton County with a tube of K-Y jelly and told her it was for use in one's anus. She asked her husband how the child would know such a thing; he suggested he'd learned it at the doctor's, where anal temperatures were usually taken.

"I said OK, and let it drop," Ms.

Hanson said. Seven months later she went to Alabama for a weeklong course in polarity therapy, a therapeutic massage she has learned to help alleviate the pain of some of her sicker patients.

In court, Mr. McAllister would ask a number of questions about the therapy. "The sphincter muscle has to relax to insert something," he recently explained. "If she teaches people to relax, she is better equipped to get the proper relaxation from that child than my client."

While she was in Alabama, Ms. Hanson left her son with friends. There were things that worried her, she said. One was that Matthew had been having increasingly severe nightmares. Another was a sudden recollection that she had always insisted doctors take his temperature under his arm.

By week's end, she says, she was in a panic. "I thought I was crazy. It was just a gut feeling more than anything."

When she returned home, she threw open the door and confronted her husband. "What the hell have you done to my son?" she screamed. "What the hell have you done to Matthew?"

It was one discussion she would be allowed to relate to the jury. According to Ms. Hanson, her husband stood up and responded. "No, you can't accuse me of that. I've been too careful. I swear I've never raped him."

'A Lot Happened to This Child'

In recounting the story today, she says his response confirmed her fears. But members of her family did not at first believe her. They would later change their minds. Initially her parents "were fixing to lock me up," she says. According to family members, Ms. Hanson was not the most reliable or stable person.

But the boy's father and his wife say they had also been concerned about Matthew's behavior — his violent outbursts and his anxiety whenever they changed their baby's diaper.

"He'd hover over me, asking very pointed questions," his stepmother said recently. "Now thinking back on it, it kills me."

Mr. Chafin calls the allegations preposterous. "I was falsely accused, period," he said. "What she [Ms. Hanson] has done is bogus. All she did was lie. I didn't do anything. I loved that child, period, as if he was my own."

About a week later, as Matthew was getting ready for bed, Ms. Hanson asked him if his stepfather had ever hurt him.

"Yes, Mommy, he put his hand and bottles and other things in me," she said he told her. She says she sat on the bed and rocked him as the two cried. "I said, 'I'm so sorry, I'm so sorry.' I just sat there and held him. That's all I could do."

NICK ARROYO/Staff

Judy Hanson and her son, Matthew, at home. The child's stepfather was accused of molesting the boy, but was acquitted on a directed verdict.

Ms. Hanson said that a few days after Matthew made his allegations, she took her son to Grady. Dr. William Robert Smith would later testify that Matthew's "rectal sphincter was very lax and allowed extremely easy passage", that the muscle tone was decreased and "abnormal." But he would not get to tell the jury how it might have gotten that way. Mr. McAllister successfully objected at almost every turn.

Mr. Chafin described the physician's testimony as ineffectual. "The doctor didn't say anything," he said. "Mildly dilated, big deal."

The day after she took Matthew to Grady, Ms. Hanson says, they went to see Detective Hank J. Derbyshire of the Clayton County Police Department. He would be the only one permitted by the judge to testify about what the child had said to him.

The testimony was graphic. In a meeting at the department, the detective said, Matthew had told him that in addition to anal intercourse, Mr. Chafin had put sticks and beer bottles in his anus.

A man with six years of investigating more than 150 child molestation cases, Detective Derbyshire said recently that the boy's description was too explicit, too detailed for a child that age unless he'd had firsthand experience. Further, he said, Dr. Smith, also experienced in child molestation cases, had told him that the condition of the child's anus was a clear sign of sexual abuse.

TRIAL Continued on **Page 36**

Trial

From Page 35

About the same time, Ms. Hanson says, she also made an appointment for Matthew to see Dr. Alexander, a psychologist in private practice with Cliff Valley Psychologists.

"He said his daddy, Ronnie, had done things to hurt him," Dr. Alexander recently said. "Using the anatomically correct doll, he said Ronnie stuck his hand in his bottom. He said, 'It didn't feel good and he made it hurt.' Later he got more graphic."

In January 1988, Matthew told Dr. Anderson that the defendant had shoved a beer bottle up his anus and anally raped him, she said. According to the psychologist, the child walked into her office one day and began drawing pictures that he then asked her to compile in a book. Because he was so young, he asked her to write the titles he gave to pictures.

"He was drawing me pictures of the abuse," she said. "He drew pictures of a beer bottle, hand, penis." She said he also told her what title he wanted her to give the book. "What Happened to Me When Ronnie Was Doing Stuff" was what he named it.

"It was about as bad a case of sexual abuse as I've seen, and I've seen a lot of cases," Dr. Alexander said recently. "A lot happened to this child."

But the jury would never hear the title of the book or her expert opinion about what had happened. Mr. McAllister objected, arguing "... these drawings ... were obtained not in a sense of let's find out what happened, but in a sense of let's see what it will take to get this child to say what we need for the prosecution of this defendant."

The judge would admit the book into evidence. But he would agree that the cover should be removed and the words inside whited out because they were in the psychologist's handwriting, not the boy's. It was a decision that would deliver a critical blow to the state's case.

Outside the courtroom, Matthew held his mother's hand and stared at the floor, his mother said. "He wouldn't talk," Ms. Hanson said. "He just stayed real close to me."

But she was not allowed to go with him into the courtroom because she was a witness in the case.

"Be a big, brave boy," Mr. Cahill recalls telling the child, ushering him to the witness stand. He was very scared, the prosecutor said.

Mr. Chafin recalls a different scenario. "I think he was wanting to come give me a hug," he said.

Matthew was put on the stand twice, first to prove his competency as a witness, then to answer questions about the alleged abuse. (This year, the Georgia Legislature abolished the competency requirement for children.)

Special

Snapshot of Ronald Chafin, who was acquitted of charges of molesting his stepson. "Nothing happened. That's why I got off," he said later.

'Flipped Out When He Saw Book'

As he testified, Matthew sat to the right of the judge, directly facing Mr. Chafin, who was about 10 feet away. "He did OK in the competency hearing, but he didn't do quite as well in front of the jury," Mr. Cahill said. "I had a hard time focusing his attention. He was nervous, not really listening to me, staring at Mr. Chafin, not really talking a lot."

According to Mr. Cahill, it was the changes in his book that upset the child the most. "He flipped out when he saw the book in court," Mr. Cahill said. "He just wouldn't speak without the book. And then when we brought it in, he was really upset."

For Mr. Cahill, it would be a turning point in the case. "Twenty some hours of work went out the window," he said. "Somehow I think the defense knew it would fluster him to have things whited out."

According to audio tapes of the trial, however, Matthew did manage to say a few things in court.

"What is all of this here?" Mr. Cahill asked Matthew, showing him the book.

"This is what Ronnie did," he said in a high, little voice, adding, "Who took the words away?"

"Who made the pictures?" Mr. Cahill asked him. "Did anyone ask you to do this?"

"No, I just wanted to," Matthew said. "So I wouldn't have to tell anybody. Could show you. Could show all them."

On cross-examination, Mr. McAllis-

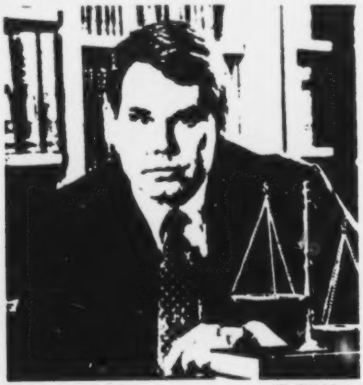
TRIAL Continued on **Page 38**

JOHNNY CRAWFORD/Staff

Clayton County Judge Joe C. Crumbley said the state had failed to prove venue "beyond a reasonable doubt"—that is, that the alleged crime had been committed in the county.

JOHNNY CRAWFORD/Staff

Defense attorney J. Dunham McAllister's objections limited the testimony of expert witnesses in the case.



NEIL BRAKE/Special

'I felt sick about the case,' Daniel J. Cahill, assistant district attorney in Clayton County, said after the trial.

Trial

From Page 36

ter sought to prove that Matthew's mother and the psychologist had coached him into doing the drawings

"This document that's been marked as S-1, who told you to draw something?" he asked the child

"I just wanted to draw something" Matthew replied

"Listen very carefully," Mr McAllister said "Who told you to draw these pictures?"

"I thought of doing it"

"When you first saw Dr Anderson, you didn't do these drawings, did you?"

"I don't think You'd have to ask my mother"

"Did your mother talk to you about doing these drawings?"

"I don't know I kind of forget real, real quick"

"So your mother talked to you about the drawings and then after she talked to you about the drawings, you went back to see Dr Anderson, is that right?"

"I think so"

Mr Cahill resumed questioning the boy "Does Mr McAllister scare you?"

"He doesn't look like Ronnie so he can't scare me" he replied adding "That shouldn't be whited out"

"Referring to the picture, why do you frown?" Mr Cahill asked

"This is when he did it to me"

"What is this right here?" Mr Cahill asked

"This was the bottle"

"What is the bottle for?"

Matthew whispered his response "He stuck it in me," the child said

"You have to tell us," Mr Cahill said "Did you tell somebody what this bottle was for?"

Silence

"Let's go to the next page Forget about what was written on there Whose hand is that?"

"Ronnie"

"Did that hand ever touch you?"

"Mm-hmm"

"Where did it touch you?"

Again the child whispered "Private part"

Mr Cahill flipped to the next page "Can you tell them what that is?" he asked the boy It was a particularly graphic picture

"You tell 'em," Matthew said

'When you get down to the bottom line, you've got a child who under the supervision of a mama and a psychologist has drawn a book and, as a result of that, says that he was touched in his private parts. We have no evidence whatsoever that is admissible properly before this jury that says that the defendant did anything'

— J. Dunham McAllister
Defense attorney

Motion for Directed Verdict

Mr Chafin says today that his stepson was brainwashed by his mother "The child was coached," he said "Think about coaching I tell you what you're going to say And a 5-year-old child who's afraid of his mama's whipping and spanking will say whatever she wants him to That's why when the child got into the courtroom, he didn't say much of anything It was a circus and it was a farce"

In court, Mr Cahill would have to do somersaults to keep up with Mr McAllister At one point, the 31-year-old attorney, then only one year into his job as a prosecutor, almost broke down in tears

"At this point I am almost thoroughly confused" Mr Cahill told the judge "Everything I've said has been objected to in this case"

Not long after that, Mr McAllister moved for a directed verdict of acquittal

"When you get down to the bottom line, you've got a child who under the supervision of a mama and a psychologist has drawn a book and as a result of that, says that he was touched in his private parts" he said "We have no evidence whatsoever that is admissible properly before this jury that says that the defendant did anything"

One of the four grounds for his motion was lack of venue Mr Cahill argued that circumstantial evidence clearly had been provided Matthew had testified that he, his mother and the defendant had lived together at his grandmother's house (the house of Mr Chafin's mother) Ms Hanson later provided the Clayton County address

According to a 1980 ruling by the Georgia Supreme Court, "Venue is a question to be decided by the jury and its decision shall not be set aside as long as there is any evidence to support it"

But after a review of the court reporter's transcript the judge decided venue had not been proved

"I realize the state has done the very best you could to prove a negative — that the child was not molested outside of Clayton County" he said to Mr Cahill "But I don't think that has been done beyond a reasonable doubt"

It was over "I think most of us just sat there with our eyes popped out" said Bobby R Cline, a juror

Defense 'Did Better Job' — Juror

As soon as the judge explained to the jury what had happened Mr Cahill left the courtroom and took the rest of the day off "I felt sick about the case" he said

Many of the jurors would blame the young, inexperienced prosecutor for not measuring up to the aggressive tactics of his opponent, Mr McAllister "The defendant's lawyer did a much better job of presenting his case" said Mr Roseberry

For his part, Mr McAllister defends his client and the way the trial was handled "If I sound hostile, it bothers me when the state wants to take a child's testimony — one that you can't even understand — and based upon that they want to put an innocent man in jail for 20 years," he said recently

Mr McAllister maintains that the exception to the hearsay rule, passed by the Georgia Legislature three years ago is unconstitutional Asked how 24 other states have enacted a similar hearsay exception with few if any challenges he replied "In my opinion, it's because the public and the bar feel the Constitution is not as important as the outcry of child abuse"

Mr Chafin is back living in his mother's home, working as a real estate broker He says he wants to put the past behind him, but he hints he may take further action against his former wife

"Anybody who knew me and who knew what was going on knew it was ridiculous," he said "Nothing happened That's why I got off If something happened to that child, she's in charge of it It's not all over I'm not finished with her"

Today the jurors say they don't know how they would have decided the case, although several said they were convinced the boy had been molested

For Matthew, distance from the trial has helped, family members say The nightmares have stopped as has some of the bizarre behavior "Now we're beginning to see the sweet little boy again" said his paternal grandmother

But the experience has left its mark on them all, she said "It's nerve-chilling to me You just never feel that you are going to be involved in anything like this"

Rights of Kids, Adults Clash Before the Bar

By Jane O. Hansen
Staff Writer

In Atlanta Municipal Court, a 4-year-old boy was recently ordered to stand and tell a robed judge the fine points of how his uncle had sexually molested him. Because the child was so small, he had to be lifted onto a table, putting him eye to eye with the judge and within arm's length of the accused.

As he stood on the table and nervously tried to answer attorneys' questions, the boy clutched the hand of Lisa W. Wise, a victim-witness assistant.

"I am appalled by how children are treated in this court," Ms. Wise said. "The judge never should have allowed it. The public defender never should have called this child to testify."

In Georgia, the abuse of children often extends into the courtroom, where the rights of defendants run smack up against society's duty to protect its children. In the struggle, children often lose.

"Unless the Constitution is amended, children can't be treated any differently [than adults]," said J. Dunham McAllister, a Jonesboro lawyer who last year successfully defended a man accused of sexually molesting his young stepson.

But critics charge there is a fundamental flaw in the legal system when the victim is a child: the failure to acknowledge that children are inherently unequal to adults and therefore need to be treated differently.

"The system is really organized to protect the rights of defendants, not children," said Ms. Wise, who is on loan to the city from the Metropolitan Atlanta Crime Commission. "Children are special witnesses and special allowances must be made for them."

In fact, a number of allowances have been enacted into state and federal law in recent years. But around Georgia, judges and prosecutors often don't take advantage of them. Sometimes, they're not even aware of them.

'You're Talking...Millions'

Since 1974, federal law has dictated that any state receiving federal child abuse and neglect funds must ensure that all alleged child victims are represented in court by a "guardian ad litem" — someone other than the prosecutor or child's family — whose sole purpose is to represent the best interests of the child. Last fiscal year, Georgia was awarded — and accepted — $354,622 in the special funds.

'The system is really organized to protect the rights of defendants, not children. Children are special witnesses and special allowances must be made for them.'

— Lisa W. Wise
Victim-witness assistant

Yet an Atlanta Journal-Constitution telephone survey — conducted March 16-24 and covering 77 of Georgia's 137 Superior Court judges — revealed that fewer than a quarter of them were aware of the law.

"I don't handle federal law," said one Middle Georgia judge as an explanation.

While most of the judges surveyed (55) said they occasionally appointed representatives for children, the majority said they did not do so on a routine basis. "Where there are only allegations [of abuse], you're talking about spending millions of dollars," said one metro Atlanta judge.

To avoid the costly use of lawyers as guardians ad litem, all but three states rely to some degree on trained volunteer citizens — called court-appointed special advocates (CASAs) — to protect children whose interests in court are often pitted against their parents'. Georgia began a CASA program earlier this year, but so far only two Georgia judges — in Newton and Hall counties — use the volunteer advocates.

Georgia is probably not alone in its failure to abide by federal law on child witnesses, say legal experts. "It's very unfortunate," said Howard A. Davidson, director of the American Bar Association's National Legal Resource Center for Child Advocacy and Protection in Washington, D.C., "because it was a clear intent of Congress that states should not receive any funding under the act unless every child in a judicial proceeding involving child abuse or neglect allegations was represented by a guardian ad litem."

Some critics blame the federal government for failing to enforce child welfare laws. Although the Children's Bureau of the U.S. Department of Health and Human Services is responsible for monitoring compliance, "we do not look at the guardian ad litem part," admitted one federal official who asked not to be named.

"They make it easy for the states to not fulfill the full intent of the law," said Kathryn M. Gannon, co-founder of the Georgia CASA program and a former Fulton County foster care worker.

Videotaping Used Infrequently

Another reform used only sporadically in Georgia's court system is videotaping — initially hailed as a means for reducing the number of times a child needs to tell his story. Under a 1986 exception to the state's hearsay law, out-of-court statements by children under 14 describing alleged abuse are admissible as evidence, as long as the child is available to testify and the statement meets standards of reliability. Georgia is one of 36 states whose law allows videotaped testimony in criminal cases.

Again, the Journal-Constitution survey showed only occasional use of the tool, with 72 percent of the judges saying videotapes were seldom if ever used in their courtrooms or during pretrial proceedings, although several indicated they would allow them if prosecutors asked.

An exception is DeKalb County, where a videotape is made of all alleged child molestation victims almost immediately after they report abuse, then used throughout the proceedings. Not only is the child spared from having to repeat his story a number of times, but the videotape captures his statement as close to the incident as possible, prosecutors say.

Without that fresh account, children dragged through lengthy court proceedings are increasingly likely to forget the details and chronology of events — a developmental disadvantage that can

RIGHTS Continued on **Page 40**

Rights

From Page 39

provide fodder for defense attorneys once the case gets to trial.

Children also may be subjected to intense pressure by family members to retract their accusations. With a videotape of the original statement, "even if he recants the testimony, it doesn't mean you can't get a conviction," said Juvenile Court Judge Virgil Costley Jr. of Newton County.

Children must testify once the case gets to trial because of a defendant's constitutional right to confront his accuser. But at the preliminary hearing, where the goal is to determine whether there is enough evidence to prosecute further, defendants have no guaranteed right to confrontation.

With the help of videotapes, prosecutors say the tapes make children into better witnesses. J. Tom Morgan, assistant district attorney in DeKalb County and the state's first prosecutor assigned full time to child sex abuse cases, has his child witnesses view their videotapes to refresh their memories, just as adult witnesses prepare by reading their signed statements.

Sometimes the tapes aid in winning convictions before the case ever gets to trial. Mr. Morgan said that thanks largely to videotapes, his county now gets confessions in 30 percent of its sex abuse cases.

Critics Cite Lack of Training

Perhaps no Georgia case has dramatized a child's plight in court as clearly as that of Ed R. Dickey of Gwinnett County, who was convicted last year of sexually molesting his two older daughters. The case jumped into the spotlight when the judge jailed one of the victims — an 18-year-old daughter — for refusing to testify against her father. The accused remained free on bond.

During the trial, the 16-year-old daughter's testimony prompted public outrage when she first collapsed on the stand and later was forced to undergo questioning by her father, who exercised his right to cross-examine her.

This case and others like it have raised what child advocates call yet another failure of the Georgia court system: the lack of training judges get in cases that deal with children.

Of the 12 hours of annual training mandated for Georgia Superior Court judges, none is devoted to issues pertaining to children, such as their developmental stages, their reliability as witnesses or — in the case of abused children — the conflicting love-hate relationship they often have with their abuser.

"Children will bond to pretty horrible people in pretty horrible relationships," said Dr. Leon A. Rosenberg, a child psychologist at Johns Hopkins University who specializes in child abuse. "They'll go out of their way to defend the parent."

The insensitivity of some Georgia judges to that kind of behavior leads to injustice, child advocates say. "Too often they're sentencing children to an abysmal life," said David Lane, executive director of the Georgia Residential Child Care Association.

Court Watchdog Groups Advocated

The best response to untrained judges is to organize a court watch group such as Mothers Against Drunk Driving, said Patricia A. Toth, director of the National Center for Prosecution of Child Abuse in Alexandria, Va.

"What seems to make the biggest difference is if the local community in which that judge sits becomes more involved in the whole problem," Ms. Toth said.

Judge Costley says he wishes citizens would hold him as accountable for what he does with children's lives as they do for how much of their tax money he spends on a new typewriter. He too advocates better training, not only for judges but also for prosecutors and other lawyers involved in abuse and neglect cases.

"I think most of them feel very uncomfortable in these situations," he said. "Think about it. A child is very difficult to examine. And if you're going to talk about very intimate situations, such as in a sex abuse case, a lot of folks are very uncomfortable talking about such intimacy."

Judge Costley is one who goes out of his way to lessen a child's trauma in court. Whenever possible, he holds hearings involving children in his chambers, where he takes off his robe and sits in his shirt sleeves. "I might turn on some music," he said. "And my office looks like a disaster so it looks like a child's room." In the waiting room, he keeps a shelf full of dolls, stuffed animals and other toys to play with.

If You'd Like to Volunteer

The Court-Appointed Special Advocates program (CASA) is a national program that uses trained volunteers to protect a child's best interests in court and beyond. Volunteers are used to help investigate children's home situations, calm a child during the trauma of a court hearing and follow the case after the court process to ensure that the child does not get lost in foster care.

If you are interested in volunteering, or if you would like to help start a CASA program in your county, please contact Kathryn Gannon (378-6029) or Nicki Vaughan (252-7988) in Atlanta.

According to the newspaper survey, a number of Georgia judges (35) believe changes should be made to alleviate the pressure on child witnesses, including a broader use of videotapes and closed-circuit TV, and more informal court procedures when children are involved.

But almost as many judges (32) said there was no need for change. "I am satisfied children are not being oppressed by the way the system is," said a central Georgia judge. (The remaining judges surveyed did not respond to the question.)

That divergence of opinion, said Judge Costley, is one reason the state needs to take a comprehensive look at its laws and procedures to see if they uphold society's mandate to protect its children.

"I think we're going to find out that they don't," he said.

One statute that was examined this year and tossed out was the competency requirement, an archaic rule that said all children under 14 had to prove to the court their competency as a witness before their case could go to trial. The change was prompted by a case involving a DeKalb County 4-year-old girl who was raped so brutally that she required seven hours of reconstructive surgery. Because she froze during the competency hearing, her case never went before a jury. And the man accused of the crime walked free.

The new legislation, passed by this year's General Assembly, leaves the decision of a child's credibility to the jury.

But even if judges were trained, reforms passed and children given the legal protections already allowed, they would remain at a distinct disadvantage in the courtroom, experts say.

"I think there still is a feeling among adults that children don't tell the truth," said Mr. Morgan. "That's always been the feeling, and these cases are very difficult to prosecute."

Yet, national studies show that deliberately false allegations of sexual abuse range between 2 percent and 10 percent of the reports. A 1983 study by the C. Henry Kempe Center in Denver, Colo., showed that when the allegations were broken down, 6 percent were fictitious reports made by adults while only 2 percent were false allegations made by children.

WALTER STRICKLIN/Staff

Juvenile Court Judge Virgil Costley Jr. says the state should review its laws and procedures to see if they uphold society's mandate to protect its children.

"In other words, you don't have a lot of kids who are deliberately lying about having been abused," Ms. Toth said.

Physical abuse cases are even tougher to prosecute because of "this prevailing attitude in our society that while it is wrong for a neighbor to beat the hell out of another neighbor, it is OK for an adult to beat the hell out of his child," Mr. Morgan said.

Georgia conviction rates bear out the premise that prosecutors are probably more willing and able to convict adults who abuse children sexually than adults who abuse children physically. Between 1985 to 1988, 1,266 people spent at least some time in a Georgia prison for a child sexual-abuse-related crime. That compares with 230 who were sentenced to prison under the state's cruelty to children felony statute, according to an analysis of Department of Corrections records.

"Everybody on the jury who's ever had children can imagine whipping a child to the point that someone else would think they're abusing them," said David E. Perry, district attorney for the Tifton Judicial Circuit. "But there's no way they can ever imagine having sex with a child."

> 'Everybody on the jury who's ever had children can imagine whipping a child to the point that someone else would think they're abusing them. But there's no way they can ever imagine having sex with a child.'
>
> **— Prosecutor David E. Perry**

Prosecutors say they often must go to extremes to convince a jury of the depravity of some adults. In Albany, N.Y., an assistant district attorney recently staged a dramatic demonstration to win a murder conviction against a man charged with killing his 3-month-old son. Under most state laws, people who beat their children to death are not charged with murder, which requires proof of intent to kill, but rather with the less serious felony of manslaughter.

To prove intent, the prosecutor asked the pathologist who had autopsied the child to show the jury what the man had done to kill his son.

Holding a baby doll by its ankles, the pathologist stood before the jury and began swinging it back and forth, violently smashing its head against the edge of a table.

The jury was convinced. The defendant, Dennis Shattell, was convicted of second-degree murder.

41

Delays, Fear Await Most Child Witnesses

By Jane O. Hansen
Staff Writer

Atlanta Municipal Court offers a magnifying glass for the problems children face in court.

In the city with probably the largest number of abused children in the state, children are routinely put on the stand in preliminary proceedings. In the county with the greatest volume of abuse cases — Fulton — there is no special unit in the district attorney's office to ensure that one prosecutor follows a case to its conclusion.

Both practices fly in the face of the American Bar Association's "Guidelines for the Fair Treatment of Child Witnesses in Cases Where Child Abuse is Alleged," which specifically recommend the use of hearsay at pretrial hearings and one prosecutor to follow a case from beginning to end.

"It's part of the whole mentality," said Kathryn M. Gannon, who helped found Georgia CASA, a court advocacy program. "Children are just not a priority in this county."

Last year, more than 150 allegedly abused children were required to testify at preliminary hearings in Atlanta Municipal Court.

"There have been cases [in the Atlanta courts] where we have seen children as young as 4 take the stand at 10 at night and refuse to talk and the magistrate court judge throws it out," said Assistant District Attorney J. Tom Morgan of neighboring DeKalb County. "We tell city of Atlanta police who have jurisdiction in DeKalb County, forget this, we do not want children from DeKalb County to have to take the stand at Atlanta Municipal Court. We will take the case straight to grand jury so that the judge will not put that child up."

At the city court, children sometimes wait for hours in a dimly lit hall where adults accused of crimes mill about, waiting for their own hearings. "This is a horrible building, the environment here is awful, just awful for anyone, let alone a child," said Lisa W. Wise, the court's victim-witness assistant. Ms. Wise often can be seen kneeling before a terrified child who is waiting on a wooden bench outside the courtrooms.

Recently, she tried to comfort a 2-year-old who was asked to testify about alleged sexual abuse by her mother's boyfriend. After waiting for three hours, the child fell asleep in Ms. Wise's arms. "I carried her up before the judge and she was asleep and he reset the hearing for a week," she said. "The judge instructed me to be sure the child was happy and fed the next time."

NICK ARROYO/Staff

Lisa Wise talks with a girl who has waited hours to testify in a child abuse case in Atlanta Municipal Court. 'The environment here is awful, just awful for anyone, let alone a child,' says Ms. Wise, the court's victim-witness assistant.

When the toddler returned the next week, they endured another long wait before the little girl and Ms. Wise were summoned for the hearing in the judge's chambers.

A police officer and a detective had already testified that the child had told them she'd been abused. But in the judge's chambers, the child froze. First she cried, then she fell asleep again in Ms. Wise's arms.

Despite her failure as a witness, the case was bound over to Superior Court for prosecution, but not before the public defender put on record that the child could not testify. "I mean we're talking about a baby," Ms. Wise said. "It's so traumatic for these kids and so unnecessary."

Judge Clinton Deveaux, Atlanta's chief Municipal Court judge, agrees that children are not treated particularly well in his court system, but he blames it on an overloaded system and a lack of any prodding by Atlanta or Fulton County prosecutors.

"There's no one saying, 'Your honors, this child shouldn't have to testify,'" he said. "That should come from the city solicitors in conjunction with the [Fulton County] D.A.'s office. The prosecutors quite frankly should make a stronger case."

Judge Deveaux said child witnesses would be better protected if the same prosecutor handled a case from start to finish. Ideally, he said, two or three people in Fulton County District Attorney Lewis R. Slaton's office should be assigned full time to children's cases.

But Mr. Slaton says the sheer number of the county's criminal cases makes that impossible. "We don't have any extra people," he said.

The district attorney also is not convinced children should get any special dispensation. "Usually the rule of thumb is they have to go through the preliminary [hearing]," he said. "They're going to be examined anyway."

He said if the abuse has been particularly traumatic, sometimes an exception is made. "If they're a tender age, we'll bring them straight to grand jury," he said. "If they're boys, we may leave them over there [in Municipal Court to testify] if the psychologist says it's OK."

Who Pays the Piper?

Recent Rulings Make Caseworkers Liable — But Only if Abuse Victims Are in State Custody

By Jane O. Hansen
And Tracy Thompson
Staff Writers

For Joshua DeShaney and Kathy Jo Taylor, childhood has been a Hobbesian proposition: nasty, brutish and short. Very short.

Joshua was 5 when his enraged Wisconsin father destroyed most of his brain in a beating. Kathy Jo was 2 when she lapsed into a coma in a Gwinnett County foster home — the result, her attorneys say, of abuse. Today, both children are brain-damaged invalids who will never enjoy life outside hospital walls.

The two cases underscore what could become the civil rights movement of the 1990s: the protection of children's rights. And, like civil rights marchers 25 years ago, children's advocates are creating unprecedented tensions in the law, raising questions that pit children against adults and family against government.

In lawsuits recently before the U.S. Supreme Court, advocates of these two children asked if the U.S. Constitution should have shielded Joshua and Kathy Jo from the adults who left them in danger. Should a child abuse victim have the right to sue authorities who knew the abuse was occurring and failed to stop it?

The answer was yes and no.

In Joshua's case, the Supreme Court ruled Feb. 22 that public officials could not be sued even when their negligence permits the abuse of a child. Key to the decision was the distinction made between a child already in the state's custody and one simply monitored by child protective service workers.

Joshua was not in the state's custody. Kathy Jo was. Wisconsin caseworkers had known for months that Joshua was being beaten, but did nothing. Gwinnett County caseworkers had already placed Kathy Jo in a foster home when she was injured, despite the fact that she had relatives who wanted her.

Less than two weeks after the DeShaney ruling, the high court refused to hear the Taylor case. In doing so, the court left intact a 1987 ruling by the 11th U.S. Circuit Court of Appeals that gave citizens the right to sue caseworkers if children were injured or killed while in the state's custody.

> 'To hold an individual social worker personally responsible for something the system has put upon her — either because she's got too many cases or is not adequately trained — isn't fair.'
>
> **— Dr. Barbara Bruner**

The effect of that ruling was to lift the shroud of immunity that had previously protected most government workers from such suits. It also means that, at least in the 11th Circuit, states — and caseworkers themselves — might now be forced to pay damages in cases where authorities have demonstrated a pattern of indifference to signs of child abuse.

Kathy Jo's attorneys already are proceeding with their lawsuit against Georgia child welfare officials. Similar suits can be expected in Florida and Alabama, which are also in the jurisdiction of the 11th Circuit. And they could potentially encompass more than child protective services workers, pinning liability charges on law enforcement officers, firemen and others who provide "protective services."

Child welfare workers argue that to take away the immunity that has shielded caseworkers from lawsuits could cripple child protective services. "If a child isn't removed from the home and something happens, the social worker is blamed," said Joan Levy Zlotnik, a staff director with the National Association of Social Workers. "If a child is removed and after a thorough investigation it's found that nothing had happened, the worker is open [to being sued] for inappropriately removing the child."

Some legal experts say the two court decisions could actually put children at greater risk by discouraging caseworkers from ever taking custody of endangered children. DeShaney says caseworkers are safe from lawsuits as long as their charges aren't in foster care or in the state's custody. Taylor says once they cross that line and take custody, then they can be held liable.

"When you take the DeShaney and Taylor decisions side by side, what the Supreme Court has in fact done has pasted a sign on all child welfare agency bulletin boards that says, 'Remove children at your own risk,'" said Don C. Keenan, an Atlanta lawyer who represents Kathy Jo.

Nevertheless, Mr. Keenan and other child advocates maintain that a bad system won't get better unless those who run it are held accountable for their actions — or for their inactions.

Every day, Dr. Barbara Bruner, director of Grady Memorial Hospital's pediatric emergency clinic, sees the products of child abuse. Daily she sees what she considers to be the products of bad decisions.

"These workers are going to do too much sometimes or too little sometimes and kids are going to die, or they're going to get harmed," she said. "Rather than say, 'We're the county, we can't be sued,' we should be aware there's a problem out there."

Her solution: county and state governments should purchase malpractice insurance. "There should be a compensation law that takes care of the problems that arise because of neglect or mistakes or whatever." Then, in clear cases of incompetence, the county Department of Family and Children Services — not individual caseworkers — should be sued, Dr. Bruner says.

"To hold an individual social worker personally responsible for something the system has put upon her — either because she's got too many cases or is not adequately trained — isn't fair," Dr. Bruner said.

But Mr. Keenan says her suggestion, while good, may be impractical. No one will purchase insurance that invites lawsuits, he says. In the meantime, Mr. Keenan says that complete immunity sends a dangerous message to child welfare workers.

"It simply says, 'You don't have to do your job,'" Mr. Keenan said. "'You don't have to follow the policies and procedures, you can be neglectful, you can be malicious. . . . You can cause loss of life, you can cause quadriplegia and, my friend, you are home free because you have got not one thing to worry about.'"

Abused Children: No Voice, No Vote, Not Much Hope

By Jane O. Hansen
Staff Writer

When police arrived, the little girl was still wearing socks soaked in her mother's blood. She had been cradled in her mother's arms when her father burst into their DeKalb County home and shot the woman dead.

The father was later indicted on a murder charge but plea-bargained down to manslaughter, for which he was convicted and sentenced to 12 years in prison.

The question in 1982 of what to do with his 3-year-old daughter — identified only as H.L.T. in court documents — was a simple one for Juvenile Court Judge Edward D. Wheeler. He took one look at the case history — the father's stint in a psychiatric hospital, the pattern of violence that had culminated in the death of his wife — and severed the man's parental rights, freeing the child to be adopted by her aunt and uncle.

The judge reasoned that the little girl had suffered the ultimate deprivation, the violent death of her mother at the hands of her father. And to do anything that could lead to the return of the child to her father "would stretch the bounds of justice beyond the breaking point."

But in Georgia, you can kill your child's mother and still be a worthy parent. At least, that's what the Georgia Court of Appeals decided when it reversed Judge Wheeler's ruling in November 1982. "Compelling facts are required to terminate parental rights," the court ruled. "There is no evidence that appellant had ever abused, injured or failed to provide for his child."

The severing of a parent's right to his child is clearly a weighty matter. But in too many cases, it's not the preservation of family that's at stake, say child welfare experts. It's the preservation of parents' rights to do whatever they want with their children.

Georgia's child protective system does not work. Shielded by confidentiality laws, the bureaucracy's failures are withheld from a public that hears only the occasional story of abuse and has little idea of how encompassing the problems have become.

SUFFER THE CHILDREN

PART 7/ANALYSIS

Yet, even when painted in numbers alone, the crisis is evident — more than 19,000 confirmed reports of abuse and neglect in 1987, 51 children dead last year who were already known to the system and under its "protective" wing.

According to child welfare experts, many of those deaths could have been prevented. The reasons why the system doesn't work are easily identifiable. So are some of the solutions, they say.

But in Georgia, there has been little impetus for change. Experts say that is because children have few advocates, other than their parents. And for abused and neglected children, their parents are often their enemies. These children don't vote. They can't afford good lawyers. They don't contribute to election campaigns.

"Everything that happens in this country is power-oriented," says David S. Liederman, executive director of the Child Welfare League of America. "If all kids have is a few people running around saying 'This is terrible and we ought to do something,' who gives a damn? And that's a real problem."

Frustration, Stress, Burnout

In the halls of Georgia's Capitol this year, lobbyists buttonholed legislators and convinced them to pump in $140 million to relieve overcrowded conditions at the state's jails and prisons. Attorneys for the imprisoned threatened to sue if something wasn't done.

Yet less than five miles from the Statehouse, children were sleeping on the floors of the unregulated Fulton County Emergency Shelter. On some nights during the session, two to three babies were crammed into single cribs. No one threatened to sue for those children.

Judging from the Legislature's response, Georgia's convicted felons can expect to be treated more humanely than abused children. So can some animals. It is a felony in Georgia to kick a police dog. It's normally a misdemeanor to kick a child.

"People are very sensitive to the suffering of animals, but they don't seem to be as sensitive to the suffering of children," says Kathern Bond of the American Humane Association, the nation's first child protective agency, which even today remains better known for its efforts to protect animals than children. "People assume children have their parents to protect them. And I think there are many people who won't believe that an adult would do this to a child."

That lack of sensitivity to children is reflected in the value placed on the people hired to protect them, says Douglas G. Greenwell, director of the state Division of Family and Children Services. The state's child protective service workers — people who are expected to walk into the most unstable of homes, make sophisticated judgments about human nature and exercise enormous control over families — earn starting salaries of $20,000. After nine years on the job, a worker with a master's in social work makes about $25,500 — less than a schoolteacher.

Once on the job, caseworkers get two weeks of training to make decisions that could alter a child's life. They're given unmanageable caseloads of often desperate families. While the Child Welfare League is about to propose national standards for caseworkers that include caseloads of no more than 17 families, some Fulton County caseworkers carry as many as 90.

Spectrum of Services Needed

"I supervise a staff that feels much frustration, high stress levels, burnout and emotional exhaustion," wrote Mary S. Brown, director of the Crisp County Department of Family and Children Services, in a recent letter to state Sen. Pierre Howard. As chairman of the Senate Human Resources Committee, Mr. Howard says he has become alarmed at the welfare system's paralysis in doing its job.

The concern he heard from Mrs. Brown is a common refrain among child welfare administrators, some of whom have seen a turnover rate of 50 percent or more in their staff during the last year. Once caseworkers do decide a child is at risk, often they can't find the services they need to ensure a child's safety.

Federal and state laws dictate that caseworkers must do everything possible to keep families intact — a worthy objective as long as children don't get left behind in dangerous situations. The statistics suggest that too often they do. Caseworkers know what services could minimize the danger, but too often they say those services aren't available.

Parents who physically abuse or neglect their children are generally poor. Among children from families earning annual salaries of less than $15,000, physical neglect is 10 times higher, serious injuries are 7 1/2 times as frequent, sexual abuse is five times greater, and fatalities three times the number found among higher-income families, according to the federal government's 1988 study of the prevalence of child abuse and neglect.

A typical abuse scenario would involve an unemployed father who starts getting collection notices in the mail, turns to drugs and eventually buckles under the stress by beating his 3-month-old baby every time she cries.

The first-line solution is not necessarily to pluck that child from her home, experts say. Rather a spectrum of services should be brought to bear. The father could benefit from job training and drug counseling, the couple from basic training in how to parent a young and demanding infant. A homemaker assigned to the family could assist the parents in getting control of their finances and help walk them through the bureaucracy to get the food stamps they qualify for.

In a New Haven, Conn., program, such services are offered by a team of professionals who work with families in their homes. Operated by Yale University's Child Study Center, the program is contracted by the child welfare department to serve families it has identified as abusive or neglectful of children. After three years, 85 percent of the children who otherwise would have been taken from their families have remained safely at home.

"And it saves the state an enormous amount of money," says Dr. Albert J. Solnit, a child psychiatrist and Sterling professor of pediatrics and psychiatry at Yale.

But there are some families that can never be fixed — many more in Georgia than the state recognizes, if child homicides are a measure.

"Initially, all efforts should be made to pour every resource that can be made available into that family — parenting skills, job training, mental health resources, education services, food, clothing, shelter," says Fulton County Juvenile Court Judge Romae Powell. "That ought to be tried no more than two years. And if they show no effort to change after that, I think their parental rights ought to be terminated. The pathetic thing is by the time we see the kid to terminate parental rights, that child is so damaged and so hurt that even if he is adopted, he can't form relationships."

Those seriously damaged children are the ones now entering the system in droves. Currently most caseworkers have two choices of where to put children who can no longer stay with family: in emergency shelters, assuming their county has one and it isn't already filled beyond capacity, or in foster families, whose numbers cannot meet the demand.

'No Will' to Improve the System

A growing number of the children are so disturbed that they need residential treatment, which is almost non-existent in Georgia. Many of these children's problems are far more serious than a foster family is trained to deal with.

"Some of these youngsters cannot tolerate the closeness of a family," says Dr. Leon A. Rosenberg, a child psychologist at Johns Hopkins University who specializes in child abuse. "It isn't always bad foster parents who grab the phone and scream, 'Get him out of here.' We need to move these kids slowly back into the world of intimate relationships. For them, a good group home is better than foster care."

There's no mystery about what is needed, says Mr. Liederman. "We know enough about the world of child welfare to know what we ought to be doing. But there's no will."

Like other states, Georgia's legislators were quick to pass laws a few years ago mandating that certain professionals report suspected child abuse and neglect. Yet the state failed to provide the programs and people needed to deal with them, according to child welfare workers and their supervisors.

"It's kind of like when we deinstitutionalized mental health institutions, then failed to provide the community services," says Mr. Howard. "And now everyone's wondering how we got so many homeless people."

To fix Georgia's child welfare system will clearly cost money. Failing to fix it, of course, could conceivably cost more. Failing to fix it may mean overcrowded jails and prisons that will be

JOHN SPINK/Staff

A brother and sister peer out at their world. For some youngsters, that world is a grim one, made so by abuse and compounded by a child welfare system that may not protect them.

HOPE Continued on **Page 46**

Hope

From Page 45

assured of a steady clientele in the years to come

According to the American Humane Association, national studies show that 85 percent to 100 percent of the nation's prison population are adults who were abused or neglected as children

"Studies have indicated astounding correlations between child abuse and deviant behavior among violent juvenile delinquents and among adults who had committed violent crimes," wrote the National Council of Juvenile and Family Court Judges in a recent report that recommends the overhaul of the nation's child protective service system "Most violent criminals have been severely physically abused as children"

Child advocates argue that the kind of money that's needed to fix the nation's child welfare systems requires a declaration of financial commitment from the nation's president, its governors and its mayors

Mr Liederman points out that last year the federal government allocated $247 million for programs that help keep children out of foster care Yet it earmarked $40 billion to help bail out the savings and loans institutions, with plans to spend billions more in the next decade

But even if this state's governor and Legislature decline to make a major new financial commitment, there are a number of things they could do to protect children

At the top of the list, experts say should be an overhaul of the way the state responds to children's deaths The Department of Human Resources's own records show that autopsies are frequently skipped, deaths of children under the department's protection are labeled as sudden infant death syndrome at four times the national rate, and suspicious deaths frequently go unheeded with no investigation

In 32 other states, child fatality review teams regularly investigate suspicious child deaths, including those of any child already known to the child welfare agency The teams are composed not only of representatives from the child welfare agency, but also from the local public health department, police department, district attorney's office and coroner's office

Around the country, these teams have uncovered invaluable information prompting new strategies for reform Minnesota has learned that its caseworkers are inadequately trained and that key players in the child protective system have not been communicating

Los Angeles and other cities' review teams have begun to put together profiles of families that are most likely to injure their children They've learned that the children at greatest risk of being killed are babies less than a year old — frequently less than 1 month — and that they're often the children of teenage parents who are poor, unemployed and involved in drugs or alcohol

"You start tying things down and you require people to talk to each other," says Dr Michael Durfee, a Los Angeles child psychiatrist recently appointed to the Presidential Commission on Child and Youth Fatalities

ANDY SHARP/Staff

A worker at the Fulton shelter helps a child from a troubled home feel more secure — at least for the moment.

Dr Durfee says that if Georgia were to create such teams, state child welfare officials would realize that caseworkers need more objective criteria for assessing the danger children are in, deciding when to remove them from their homes and when it is safe to return them And prosecutors might conclude they need to devote the same amount of zeal to physical abuse and neglect as they now do to sexual abuse

"I think we are so caught up in sexual abuse for the moment that we have forgotten why the child protective service system in this country was ever set up," says Dr Richard D Krugman, executive director of the C Henry Kempe Center in Denver "And that was for physical abuse and deaths, plus we continue to neglect neglect"

Lack of Data on Child Fatalities

For the first time, state officials could begin to define the parameters of the child fatalities problem In Georgia no one knows how many children have been beaten to death The dearth of such data is national in scope

"The fact that the federal government hasn't made it a priority to try and count these deaths is appalling," says Dr Krugman "If you call up the federal government and ask how many Hondas came into the United States this year they will tell you to the Honda"

Reviews of Georgia's dead children would also underline what many see as a critical need to put medically trained examiners — instead of elected coroners —in charge of death investigations Today, coroners need only have a high school education, and most have no medical training Yet they are empowered to say how people died

Without higher standards for Georgia's coroners, child fatality review teams probably would be a wasted effort "If the coroner's system is lousy, you can't build the system," says Dr Durfee

Weaknesses in other points of the system might also come to light

Experts say Georgia's teachers and counselors need to be trained in recognizing abused and neglected children, then encouraged to work with child protective service workers once they report such cases Hospitals should be required by state law to report all drug addicted infants to child protective services, something they're currently not required to do Physicians must be more willing to report abuse and testify in court about it, which they are often reluctant to do, according to prosecutors

Some argue that Georgia's judges also need mandatory training in child development and the signs of physical and sexual abuse and neglect "There are still many judges who put the sanc

ANDY SHARP Staff

Phyllis Williams feeds two toddlers at the Fulton County Emergency Shelter, which provides refuge to many abused children. 'You hate to see the children like this,' she says.

tity of the family above the rights of the child," says Ms. Bond of the American Humane Association. "They say, 'But this father has a right to be with his child. I don't care if he is sexually abusing her.'"

Finally, child advocates say legislators need to reconsider the entire area of confidentiality, which they say is used as often to protect the system's failures from public scrutiny as it is to protect children's lives.

In death cases, particularly, child advocates question whose interests are served by keeping those records private — the child's? The child is dead. The parents? They may be murderers.

In the state of Washington, when details of the death of 3-year-old Eli Creekmore at the hands of his father became known — he was beaten to death at the dinner table when he could not stop crying — the public was outraged and demanded a more accountable system. Embodied in new legislation is the notion that a child's safety and individual rights must take priority over keeping the family together.

Georgia probably has its Eli Creekmores. The public just doesn't know about them.

Ultimately it is up to the community to fix the system, to make it accountable.

'A Web of Sadness'

The problems of the child welfare system go far beyond the capabilities of the Departments of Family and Children Services to solve. "There are a lot of things that have to occur before we can say we're winning the war," says Gerald V. Gouge, chief of the state's child protective services unit. "One of the things I'd like to see is for the Legislature to outlaw corporal punishment. It would be a significant statement. Children are not objects to take out your anger on."

But attitudes toward children are not likely to change quickly. Those who deal daily with mistreated children say they are hampered most by the public's unwillingness to believe that people do horrible things to their children. It's one thing to see the statistics. It's another to see the children's faces.

In her book, "Orphans," author Eileen Simpson explains why for years on her way to work she avoided visiting the Hopewell Orphanage in New Jersey, even though she herself had grown up an orphan.

"There was no missing this large red brick building. It stood naked in a field, with neither trees nor shrubs to soften its bulky outline. Whenever I passed it, I said to myself that the next time I must go in and volunteer my professional services. There was surely something I could do for the children. But each time I made an excuse.

"It was fear of being pulled by invisible strings into a web of sadness that made me accelerate rather than slow down on the Hopewell road. For me, the children's eyes would have unspoken messages: 'You were more fortunate than we are,' they would say. Or, more distressingly, 'Take us with you.'"

What You Can Do to Help

Grady Memorial Hospital Volunteer Services Office, 589-4360

Screened volunteers are used to hold, feed and play with infants and children, some of whom have been abandoned to live at the hospital. Organizations can "adopt a crib" by furnishing a baby's crib with mobiles, toys, etc.

Volunteer Cordinators for Family and Children Services

Each county Department of Family and Children Services is supposed to have a volunteer coordinator to assist people willing to volunteer their time and money to help children. Agencies welcome donations to help send needy children to camp, the circus, etc. They are in constant need of diapers, baby food, canned and boxed goods for hungry families that show up at their doorstep. If the county department is unable to help, call 656-4937.

Foster Care Contacts

People who wish to be considered as foster parents should call their local Department of Family and Children Services. The state foster care number is 894-4139.

Adoption Contacts

People who wish to adopt a hard-to-place child in the state's custody can call My Turn Now in Atlanta (894-3748) or call their local Department of Family and Children Services. The state adoption office number is 894-3376.

Court-Appointed Special Advocates (CASA) program

This national program relies on volunteer citizens trained to follow a child abuse victim's case through the court process and beyond. CASAs help investigate children's home situations, make recommendations for placement to the judge, sit with children in the courtroom to calm their fears, and follow their case after disposition to make sure they don't drift in foster care. For more information call Kathryn Gannon at 378-6029 or Nicki Vaughan at 252-7988 in Atlanta.

Lisa W. Wise, Victim-witness Coordinator, 658-6392

Screened volunteers are needed to shepherd allegedly abused or neglected children through preliminary proceedings in Atlanta Municipal Court — sitting with them as they wait and possibly accompanying them into the courtroom or judge's chambers.

Judicial Citizen Review Panels, 656-5171

Under federal law, the cases of all foster care children must be reviewed every six months to ensure that the children do not fall through the cracks. The majority of Georgia counties rely on internal reviews by local Department of Family and Children Services. But a growing number are inviting volunteers to sit on the panels to offer an outside perspective. Currently, 29 counties involve citizens on these panels. For information on which counties do involve citizens or how to establish a citizen review panel in a county, call Pamela Borne with the state Administrative Office of the Courts.

Georgia Council on Child Abuse, 870-6565

The council uses volunteers for a variety of activities, including manning a telephone hot line (1-800-532-3208) for anyone in Georgia seeking information about child abuse — from parents who may be abusers to citizens who wonder what the indicators of abuse are.

Emergency Shelters

Concerned citizens interested in establishing an emergency shelter for abused and neglected children can contact local county and city officials to explore the possibility.

Court-watch Groups

Those interested in court-watch groups for abused and neglected children — patterned after Mothers Against Drunk Driving (MADD) — can contact the National Center for the Prosecution of Child Abuse, located in Alexandria, Va. (703) 739-0321.

Georgia Alliance for Children, Richard McDevitt, 588-0708

Mr. McDevitt is a professional child advocate who can offer a variety of suggestions to individuals who wish to see reforms in the state's child welfare system.

Phone Numbers of Officials

Gov. Joe Frank Harris, 656-1776

Attorney General Michael J. Bowers, 656-4585

Commissioner James G. Ledbetter, Department of Human Resources, 656-5680

Douglas G. Greenwell, DHR's Division of Family and Children Services, 894-6386

Lt. Gov. Zell Miller, 656-5030

House Speaker Tom Murphy, 656-5020

Sen. Terrell Starr, Senate Appropriations, 656-7586

Rep. Lauren McDonald, House Appropriations, 656-5052

Sen. Pierre Howard, Senate Human Resources, 656-5110

Rep. E.M. Childers, House Health and Ecology, 656-5141

Rep. Betty J. Clark, House Human Relations and Aging Committee, 656-5139

Call Your Legislator

To find out who your legislators are, call your county voter registration office. To locate them, call the public information office of the House, 656-5082, or of the Senate, 656-0028.

For Parents Who Need Help

For those parents who need help — who are mistreating their children or fear they might — the Georgia Council on Child Abuse operates a 24-hour hot line. All calls are considered confidential. The number is 1-800-532-3208.

To report suspected child abuse or neglect call 894-2698.

State Leaders Urge Reforms To Help Abused Youngsters

House-Senate Panel Proposed to Draft Measures

Thursday, June 15

By Jane O. Hansen
Staff Writer

SUFFER THE CHILDREN
FOLLOW UP

State government leaders — saying abused and neglected children have remained too long at the bottom of Georgia's priorities — have called this week for a number of reforms in the state's child welfare system, including the regular investigation of suspicious deaths and a greater financial commitment to protective services.

On the heels of last week's publication of "Suffer the Children" — an Atlanta Journal-Constitution series on the failures of Georgia's child protective system — Lt. Gov. Zell Miller said Wednesday that he will recommend to House Speaker Tom Murphy the creation of a joint House-Senate study committee to draft legislation in time for next year's General Assembly.

"It's really a shame that we have to wait until the newspaper calls our attention to these problems as dramatically as this before we do something," said Mr. Miller, a candidate for governor.

State officials, including Gov. Joe Frank Harris, said they were moved by the newspaper accounts of children who have been abused by their parents, lost in foster care or failed by often insensitive court and child welfare systems.

"The newspaper's articles threw a glaring light on the atrocities visited daily on innocent babies and children," Mr. Harris said Wednesday. "More often than not, these tiny helpless beings are hurt, neglected, even killed by those who bear them, father them, live with them or who care for them. I feel both a tremendous sadness and a moral outrage that some in our society place such little value on children and that the systems designed and funded to protect them so often do not work."

Mr. Harris said he anticipates that a Nov. 10 conference sponsored by the governor's Commission on Children and Youth will result in some concrete plans for improving the child welfare system.

"I believe this series will galvanize the commitment to produce some real action from the conference," he said.

Among its findings, the newspaper reported that a few miles from the Statehouse, the Fulton County Emergency Shelter is so overcrowded that babies are sometimes crammed two and three to a crib and children often sleep on the floor.

"I am appalled by what is going on," said Sen. David Scott (D-Atlanta), who proposed to Mr. Miller the idea of a joint committee.

Sen. Pierre Howard, chairman of the Senate Human Resources Committee, says he will propose a package of legislation this fall. "The series pointed up graphically the need to make children and their concerns the top priority issue in Georgia," said Mr. Howard (D-Decatur), who is a candidate for lieutenant governor. "It should be at the top of the public agenda."

Rep. Johnny Isakson (R-Marietta), who hopes to be the Republican Party's gubernatorial nominee, said the Legislature needs to set standards for the review and investigation of suspicious deaths of children. The series pointed out that Georgia is one of 10 states not keeping statistics of how many children are killed by their parents — the No. 1 murderers of children under 5. Georgia is one of 18 states with no child fatality review team to investigate suspicious deaths.

"Any suspicious death or suspicious injury of a child should be investigated in the same way that it would be of an adult," said Mr. Isakson, House minority leader.

Children also need more protection in court, said Mr. Isakson, who last session introduced a bill establishing a statewide Court-Appointed Special Advocates (CASA) program. The bill is in committee. Through the CASA program, children in Juvenile Court hearings would be assigned a special guardian to represent their interests. Although federal law requires such guardians for any child involved in an abuse or neglect hearing, Georgia judges have routinely failed to appoint them.

Mr. Miller said he was struck by the tragedies the state's child protective service workers face daily. "I don't see how they do it," he said. "My heart goes out to them."

He said one of the primary focuses of the joint legislative committee should be the state's confidentiality statutes, which many child advocates say are designed more to shield the system's failures from scrutiny than to protect children and families.

"I think we need to re-examine whether in some instances secrecy does more harm than it does good," Mr. Miller said. "It seems to me that greater openness would also give us a better handle on what we need to do."

Sen. Roy Barnes (D-Mableton), another candidate for governor, said that in addition to relaxing confidentiality statutes, Georgia's judges should be required to get training in child development and child abuse symptoms.

Mr. Barnes said the newspaper series underscores that "the priorities of the state's leaders have not caught up with the actual needs of the people."

"Our politics and legislation over the years have been asphalt-driven, rather than driven by human services," he said. "We dump everything into our child welfare and social services network and expect them to solve all the problems. But when it comes time to give them money, we don't do so."

Rep. Lauren "Bubba" McDonald (D-Commerce), chairman of the House Appropriations Committee and another candidate for governor, said the recently approved 1-cent increase in the state sales tax could finance some of the programs child welfare experts say they need to protect children.

Mr. Murphy said Wednesday that he had not read the newspaper series but planned to do so. Although the relationship between the speaker and lieutenant governor has been strained in recent years, Mr. Miller said he would work with Mr. Murphy to create a joint House and Senate committee.

"I'll get on the phone with him about it, see what he wants to do," Mr. Miller said, adding the committee should be "started immediately." "I'm ready to take whatever steps are necessary to set it up."

Police Reopen Inquiry Into Deaths

Officials Question Mother's Accounts, Their Findings

Saturday, Jan. 8

By Jane O. Hansen
Staff Writer

James William, a bubbly fair-haired boy of 2, simply didn't wake up the morning of Sept. 25, 1977. The Fulton County death certificate says he died of sudden infant death syndrome (SIDS).

Three years later, another of Martha Ann Johnson's children died in her sleep. Tibitha Janeel, 3 months old, also was listed as a victim of SIDS, according to medical records.

On Feb. 15, 1981, Earl Wayne, 2 1/2, became the third of Mrs. Johnson's children to die. Cause of death: "seizure disorder of unknown etiology." After his funeral, Mrs. Johnson's last surviving child — 11-year-old Jennyann — told her father and a Fulton County social worker that she was afraid to remain at home with her mother.

Social workers interviewed the family but thought they had no legal justification for removing the child. Police and medical examiners investigated the deaths but found no proof of homicide. After a while, they all dropped their investigations.

On Feb. 21, 1982, Clayton County police found Jennyann dressed in a "Let's Boogie" T-shirt and lying face down on a bed at her mother's home. She was dead when they got there. A medical examiner later wrote that she died of "probable asphyxia" of "undetermined cause."

Mrs. Johnson, 34, said last week that she cries often over the loss of her four children. A clerk at a convenience store in Locust Grove south of Atlanta, she has remarried, moved into a new community and worked hard to forget the past and make a new life for herself.

"I think it was just bad luck," Mrs. Johnson said of her children's deaths. "There wasn't nothin' I wouldn't do for them."

Seven years after the death of Jennyann, law enforcement and medical officials remain unconvinced that bad luck caused the children's deaths.

Last week, following inquiries by The Atlanta Journal-Constitution, Clayton County police reopened the investigation of the deaths as possible homicides. According to Maj. Jerry Wayne Robinson, Mrs. Johnson is a suspect.

In addition, the medical examiner who performed the autopsy on James 11 years ago now says he may have been wrong in listing SIDS as the cause of death. Dr. William R. Anderson, today an associate county medical examiner in Naples, Fla., has requested all four children's autopsy reports from Fulton County and plans to issue a formal report.

"I wouldn't hesitate to say that there's a 90 percent chance that this is homicide," he said.

As early as the second child's death, Earl S. Bowen, Mrs. Johnson's husband at the time, told the Fulton County medical examiner he was suspicious. Officials confirm that Mr. Bowen and others told them shortly after Tibitha died that each death was preceded by a marital dispute and Mr. Bowen's departure from the house.

"Each time, one of them would die after I would leave," Mr. Bowen said. Mr. Bowen, one of Mrs. Johnson's four husbands and the father of Tibitha and Earl Wayne, lived with her at the time of the children's deaths.

After Jennyann died, the case was looked into extensively — but as mysteriously as the children died, officials in Clayton and Fulton counties dropped their investigations.

"To me, there's a lot of unanswered questions," Mr. Bowen said.

Among them are why two departments of Family and Children Services failed to follow up on Jennyann, why the Clayton County district attorney did not prosecute as police say they recommended, and why the Clayton County coroner did not conduct an inquest after receiving a medical examiner's report marked, "suspicious, this 11-year

RICH ADDICKS/Staff

Jennyann Wright, Earl Wayne Bowen and Tibitha Janeel Bowen, shown in a family portrait. All three children, along with James William Taylor, died while in the care of their mother, Martha Ann Johnson, right.

old Caucasian female is the fourth child in the family to die following domestic arguments between the parents "

Officials say today that they had no proof of homicide, so they stopped working on the case Authorities say another reason the case fell through the cracks was that the deaths occurred in different jurisdictions Different police departments, different medical examiners, different hospitals and different social service agencies were involved, and few communicated

But those who worked on the case have not forgotten it "This case was one of the nightmares that a medical examiner dreads," said Fulton County medical examiner Saleh A Zaki "It's just about the worst case that I've had Because if these are murders, and we failed to make that diagnosis, we failed to do our job "

'Question Mark on First Case'

Medical records show that James William — or J W as he was called — was a healthy, brown-eyed, blond haired boy of almost 2 years the last night his mother put him to bed

Earlier in the day, she and the man she was living with and later married — Earl Bowen — had gotten into an argument

"She always thought that I was running around and everything " Mr Bowen, a driver for Marriott In-Flite Service, said in a statement years later to College Park police "All we done was argue all the time, so I just decided that I would go ahead and leave to keep it away from the kids "

In her statement to police at the same time, Mrs Johnson — then Martha Ann Bowen — said that the next day she got up as usual and started to fix the toddler's breakfast

"He likes cereal or egg, so I went in there to get him to see which one he wanted," she said in her statement "Then when I went in there, around his mouth was blue, and his hands He would not never move "

Dr Anderson, who was covering for Fulton County medical examiners on weekends, performed the autopsy and later signed the cause of death as SIDS, an affliction that generally strikes healthy babies and whose cause is unknown But according to Dr Zaki, the records show that Dr Anderson must have hesitated before signing the cause of death

"There was a question mark on the first case — something that was not right," he said

The problem was the child's age According to a recent national study on the incidence of SIDS, 90 percent of SIDS deaths occur before the age of 6 months, 98 percent before the first birthday J W was one month short of his second birthday when he died In the 1970s, however, little was known about the syndrome

On Feb 15, 1981, Earl Wayne, 2 1/2, became the third of Mrs Johnson's children to die Cause of death: 'seizure disorder of unknown etiology.'

Dr Anderson said that until a recent telephone call from a reporter, he had not known that the three other children in the family had died Had he known, he might have reviewed his own findings sooner, he said

A little more than three years after J W 's death, in November 1980, the couple again had an argument that prompted Mr Bowen to stay with a friend, Stanley Hullen By this time, the couple had married

Mr Hullen recalled that Mrs Johnson (then Mrs Bowen) telephoned that night looking for her husband "She said, and I will never forget these words as long as I live, 'If anything happens to the daughter, it will be Earl's fault,' " said Mr Hullen, now a senior customer service agent for Delta Air Lines in Tampa, Fla

(Mrs Johnson said last week she never made such a call "I've never said nothing like that about my kids," she said) That night, according to her statement to police, Mrs Johnson was taking a shower when Tibitha stopped breathing "The night she died, we found M & M's on the bed," she said in her statement She suggested that her toddler son, Earl Wayne, may have fed them to the infant "I don't know if he stuck something in her mouth or not," she said "Because when my oldest daughter came in there and told me that [Tibitha] was gasping for breath, I got out as fast I could to go in there to her Because I love my kids "

The baby was dead on arrival at South Fulton Hospital At the hospital, Mrs Johnson said her husband accused her of having done something to the child "He said he knew that the baby was all right when he saw her that afternoon " she said in her statement to police

"He said that I did something to it I told him if I did not want them, why would I carry them for nine months "

Dr Zaki performed the autopsy and called it a typical SIDS There were no signs of M & Ms or any other obstruction A week later, Mr Bowen visited Dr Zaki at his office "He said, 'Dr Zaki, I want to tell you something' " Dr Zaki recalled " 'We had a child before who died a couple of years ago And he was also diagnosed as SIDS, and he was about 2 years old ' He said the deaths happened the next day that he threatened his wife to leave her or he left her or something like that "

Dr Zaki said that was his first clue that something might be wrong He immediately went back and reviewed his autopsy and the one that had been done on J W "Once I did this, I realized that even the pathologist in the first case had some doubts at the time that this was SIDS, I think because of the age," he said

He remembers discussing the case with two of his investigators, to see if they could collect any more information about the family or the circumstances of the children's deaths But nothing came of it

Dr Zaki saved a blood sample from Tibitha He said he had a gut feeling that it might be a good idea to hold onto it

A Social Worker's Nightmare

"Wayne," as he was called, was like a son to Vernon G Bowen, the boy's uncle "I'll never forget him," said Mr Bowen, a gravedigger at the College Park Cemetery where the children are buried in a section called Babyland "Yeah, I sure do miss him My brother, he really took it hard I thought he was fixing to commit suicide "

About three weeks before his death, medical records show that Wayne's mother took him to the South Fulton Hospital Emergency Room, complaining that the child might have eaten some rat poison

According to her husband, the couple had argued a couple of days earlier and he had gone to stay with his older brother

For the next few weeks, Wayne's mother took him back and forth to the hospital, complaining that the boy was having seizures

One night, Mr Hullen said, she called him, inquiring as to her husband's whereabouts "She said, and I quote again, 'If anything happens to Wayne, it is Earl's fault,' " Mr Hullen said "The same exact words A fire went off in my brain "

(Again, Mrs Johnson denied last week that she ever made such a call) Immediately, Mr Hullen called the Fulton County Department of Family and Children Services, urging them to remove Wayne and Jennyann from their mother's home

A social worker there asked him if Mrs Johnson was abusing her children "I said, 'No, she's not abusing them, she's killing them,' " a weeping Mr Hullen said last week

That social worker, Vale Henson, remembers well the conversations with Mr Hullen Like Dr Zaki, she recalled the case as the worst of her career

INQUIRY Continued on **Page 52**

Inquiry

From Page 51

"I had gotten a call from this man reporting that every time his friend left his wife, one of the children would die," said Ms Henson, who now works as a social worker for DeKalb County

From the onset, Ms Henson was suspicious about the first child's death, based on his age "Sometimes I think the medical examiners are quick to tag babies as [SIDS]," she said recently

At Mrs Johnson's home, Ms Henson played with Wayne and talked with the mother "The little bad 3-year-old turned my pocketbook upside down and wasted all my stuff on the floor," she recalled "[The mother] handled that real well She said 'Don't do that Don't throw Ms Henson's things all over the place I'm sorry, Ms Henson'

"So I left the child there I stayed with that woman a good two hours Because everything was so strange about the case, I did not want to leave any stone unturned I did not want to leave a 3-year-old there who might die And I felt real comfortable when I left there, that I had done the right thing"

The next day, Mr Hullen called Ms Henson again, asking why she had left Wayne with his mother Ms Henson told him she knew what she was doing and could no longer discuss the case with him

"So here I am thinking I'm an expert and I had assessed it just right," Ms Henson said Two days later she got a call from the hospital On Thursday morning Feb 12, 1981, Mr Bowen called and spoke to Wayne on the phone The couple had remained separated since shortly before Wayne's seizures started "I hadn't talked to Ann for about two weeks," he said

He said he had been avoiding her because he did not want her to know that he had hired a lawyer and planned to file for custody of Wayne "I was scared of what she might have done if she knew it," he said last week "It happened anyway It's a nightmare"

That morning, he said, it came out during their phone conversation that he was going to fight for his son

"There wasn't nothing mentioned about him having custody of the children" Mrs Johnson said last week

Later that afternoon, Mr Bowen's wife called him at work and told him that Wayne had had another seizure and was very pale He left immediately to meet her at the hospital

Mrs Johnson said in her statement to police that Jennyann held Wayne in her arms as she sped to South Fulton Hospital "But he had died in my daughter's arms between the house and the hospital," she said "He was so limber when I picked him up and took him into the hospital, but I did not know that he was dead"

Three days later, Wayne was declared brain dead at Henrietta Egleston Hospital for Children, where he had been transferred

Third Death Sets Off Inquiry

The next day, Mr Hullen phoned Ms Henson in a rage "I called and said, 'I hope you are satisfied 'cause you didn't do nothing Another child has died'" For a week Ms Henson didn't sleep "I had left this baby in that home," she said She even went to Wayne's funeral During that time, one physician called her at home, ranting and raving and accusing her of failing to do her job Ms Henson burned a whole pan of pork chops as they talked

When she asked the physician whether he would have agreed to go to court and sign a petition saying Wayne's seizures were due to abuse or neglect, he said no Without it, she said, the courts would have refused to let her take custody away from the mother

One problem with the case, said Dr Zaki, was that there were never any signs that the children were being abused "These are not battered children," he said "And this is one of the worst problems of this case to me, that they are not battered children"

When Dr Zaki heard of the third child's death, he called it "the shock of my life" He immediately phoned the physicians at Egleston and asked them to retain tissues, "so that if there are poisons involved, we can check for it," he said "The idea of poisoning had to be looked at carefully here

"And I talked to people in the crime laboratory to look at the specimens And I remember also calling the CDC [national Centers for Disease Control] After all this, I don't think we reached any conclusion"

By this time, the College Park police were called into the case, and Mrs Johnson was asked to come in for questioning

"I remember going over the autopsy results with the medical examiner to see if he could tell us if there was foul play involved, and he just couldn't," said College Park Police Chief W T Sheets, who was then a captain "When you get a death like what we're talking about, it's up to the medical examiner to use evidence from the remains to help us If he can't give us a definite cause of death that would indicate foul play, we have to keep investigating it If we turn up something, fine If we don't, then we don't"

After Wayne died, Mr Bowen and his wife put their divorce proceedings on hold, and for awhile he moved back in with her But he says he felt uneasy about leaving his stepdaughter, Jennyann, with her mother So he went to see her natural father, Bobby E Wright

"I felt that she would be safer with him, because I didn't know what was happening with my kids," he said "He kept her for about three or four days, then took her to Ann's mama's Then after that, Ann just got her back"

In hindsight, Mr Bowen, Mr Hullen and Mr Wright said they believe Jennyann knew something "I was talking to her once about the kids passing away," Mr Bowen said "I asked her did she know something about what happened to those kids She just pulled away, got real scared and I never could get her to talk about it again

Her father also noticed that Jennyann obviously was distressed

"About a month before she died," he said, "I went to pick her up for one weekend" In the car, Jennyann told him about a dream in which her mother was standing by her bed holding a pillow over the girl's face

"She told me that she was very afraid," Mr Wright said "I should have listened to her"

Ms Henson also recalled talking to Jennyann shortly after Wayne's death "The 10-year-old was scared to death," she said "After the 3-year-old died, I went out there one day, and she says, 'Ms Henson, I don't want to stay here'" Since all three children's deaths had been recorded as natural, however, Ms Henson thought the courts would not grant the state custody of the child The best she could do was informally arrange for Jennyann to stay with a relative

Shortly after, the case was transferred to the Clayton County Department of Family and Children Services because officials realized that the Bowen family was living in Clayton County, not Fulton County

Ms Henson was taken off the case

On Feb 21, 1982 — almost exactly one year after Wayne had died — Clayton County Patrolman G Lewis Turner and Capt Robert A Brown were on the morning watch when the call came in around 11 p m

"We hadn't been on the road very long when we got a sick call," recalled Patrolman Turner They arrived at the house before the emergency rescue team did Patrolman Turner stayed outside with Mrs Johnson while Captain Brown went into the bedroom where Jennyann lay face down on a bed, wearing white underpants and a white T-shirt She was dead at the scene

Mother Suspected of Killing 4 Children Charged in One Death

Tuesday, July 4

By Jane O. Hansen
Staff Writer

Martha Ann Johnson, 34, suspected of killing her four children one by one over a five-year span, was arrested Monday night and charged with the murder of the eldest of them, 11-year-old Jennyann Wright.

Mrs. Johnson was arrested at her home by Henry County sheriff's deputies on a warrant issued in Clayton County, according to a statement by Clayton County police. She was being held without bond in the Clayton County Jail.

"The case was reopened on Dec. 20, 1988, as a result of inquiries by The Atlanta Journal-Constitution," said Sgt. Ken Stewart, who led the investigation. A statement issued by the department says, "The investigation has been ongoing since that time, culminating in today's arrest."

The children, whose ages ranged from 3 months to 11 years, died mysteriously between 1977 and 1982. All four deaths were preceded by an argument between Mrs. Johnson and her husband at the time, Earl S. Bowen. Mr. Bowen moved out of the house before each death.

Police and medical examiners investigated the third and fourth children's deaths, but they could find no conclusive evidence of foul play. The case was finally dropped not long after Jennyann's death Feb. 21, 1982, of "probable asphyxia" of undetermined cause.

The first to die, James William Taylor, a bubbly, fair-haired boy of 2, simply didn't wake up the morning of Sept. 25, 1977. The Fulton County death certificate put it down to sudden infant death syndrome (SIDS).

Three years later, Tibitha Janeel Bowen, 3 months old, died in her sleep, and that death also was listed as SIDS, according to medical records.

On Feb. 15, 1981, Earl Wayne Bowen, 2 1/2, became the third of Mrs. Johnson's children to die. His death was blamed on "seizure disorder of unknown etiology."

After his funeral, Jennyann told her father and a Fulton County social worker that she was afraid to remain at home with her mother.

Social workers interviewed the family but thought they had no legal justification for removing the child. Police and medical examiners investigated the deaths but found no proof of homicide. After a while, they all dropped their investigations. Mrs. Johnson put the deaths down to "bad luck."

The case was assigned to Sargeant Stewart, who said Monday night Mrs. Johnson's arrest was "the culmination of an extensive and very meticulous investigation."

"This does not close it," said Sergeant Stewart. "It just adds some things to it. I've got good information on two of the four, and I'm not going to close the case just because I have some information at this point."

He refused to comment further, but sources close to the investigation said murder charges are likely to be added soon in the death of James William.

Mrs. Johnson has high blood pressure and heart trouble, authorities said, and Henry County fire department medical personnel accompanied deputies to the woman's home.

Clayton County District Attorney Robert E. Keller said Monday night that the case probably would be presented to the grand jury within two weeks.

Mother Admits Killing 2 Children, Police Say

Thursday, July 6

By Jane O. Hansen
Staff Writer

Martha Ann Johnson has told police that she killed two of her four children by smothering them, authorities said Wednesday.

Director Ronnie F. Clackum of the Clayton County Police Department and Police Chief Walter T. Sheets of College Park confirmed Wednesday that several hours before her arrest on Monday Mrs. Johnson, 34, confessed to killing 2-year-old James William Taylor and 11-year-old Jennyann Wright, her children from two previous marriages.

The police officials refused to say how Mrs. Johnson allegedly smothered the children, but others familiar with the case said the large woman told police she lay on top of them as they slept.

Clayton County District Attorney Robert E. Keller said he planned to go to the grand jury today to seek murder charges against Mrs. Johnson in the 1982 death of Jennyann, in the February 1981 death of her 3-year-old son, Earl Wayne Bowen, and in the 1980 death of her 3-month-old daughter, Tibitha Janeel Bowen. Mr. Clackum said Mrs. Johnson has confessed only to the deaths of Jennyann and James William.

James William, who in 1977 was the first of the four children to die, is a College Park case and is thus in the jurisdiction of Fulton County District Attorney Lewis Slaton, Mr. Keller said.

Authorities had become suspicious as early as Tibitha Janeel's death. At that time, they became aware that a dispute between Mrs. Johnson and her husband at the time, Earl S. Bowen, preceded both deaths and that Mr. Bowen both times had left the house following the dispute.

Medical examiners at the time attributed the deaths of both James William and Tibitha Janeel to sudden infant death syndrome (SIDS).

A number of agencies in Fulton and Clayton counties investigated the two deaths. Suspicion heightened when the third child, Earl Wayne, died of "seizure disorder of unknown etiology" following another marital dispute.

Subsequently, police and child protective service workers placed Jennyann with a relative, after the child said she was afraid to remain with her mother. But unknown to authorities, Mrs. Johnson got her daughter back, and on Feb. 21, 1982, the 11-year-old was found face down on a bed in her mother's home. The cause of death was "unexplained asphyxia," according to autopsy reports.

Although suspicious, police and medical examiners dropped the case not long after Jennyann died, saying they could find no evidence of homicide.

Protecting the Children of Neglect

Sunday, June 11 — The Atlanta Journal-Constitution

The 2-year-old with cigarette burns covering his frail body, the 3-year-old found bleeding from her vagina, the four siblings who died mysteriously, one after another, before caseworkers and medical examiners compared notes, implicating their mother, the infant placed in the custody of a man who had brutally murdered her mother.

It's hard to dismiss these heart-wrenching images from reporter Jane O. Hansen's series "Suffer the Children" as aberrations in a state that keeps no records on the number killed by their parents, that records suspicious deaths innocuously as sudden infant death syndrome at four times the national rate, that ignores federal laws requiring the appointment of child advocates in court, that failed last year to prevent the violent deaths of 51 youngsters it had placed in "protective" custody.

If there was one theme running through Ms. Hansen's blistering indictment of Georgia's child-welfare system, which concluded Saturday, it was the complicity or indifference of hundreds of agencies and individuals who might have made a difference.

Laws that exalt "parental rights" unreasonably over the rights of children to grow up free of beatings, sexual molestation or abandonment are scrupulously enforced in Georgia. Laws designed to protect children in court, and provide for autopsies in suspicious deaths, are not.

Child protective service workers, the first line of defense against child abuse and the ones making life-or-death determinations about whether to remove children from their homes, are poorly trained, paid less than first-year schoolteachers and under pressure to keep families together at all costs; if they act precipitously, they are personally vulnerable to lawsuits.

If a child is taken from his parents, there may be no place for him to go; foster homes are so scarce some children are kept indefinitely in crowded emergency shelters, hospitals or homes where they are being abused. Even then, red tape or exalted respect for "parental rights" can keep them unavailable for adoption until they are too old or too scarred by abuse to be readily adoptable.

This inexcusably shabby treatment of Georgia children, often cloaked by "confidentiality" statutes that have tended to shield not children but parental and bureaucratic failure, is all the more appalling in light of evidence that most violent criminals were abused as children.

There's no mystery about what must be done. The governor and the Legislature can have a major impact by rewriting laws and reordering priorities that devalue children. They should fund parenting, job-training and mental-health assistance for abusive parents and set time limits on "parental rights" in order to free abused children for adoption.

They should remove obstacles to adoption by single parents and lobby Congress to repeal unwieldy confidentiality laws. They could provide malpractice insurance and higher salaries for child welfare workers and broaden the use of videotaped testimony and child advocates in court.

Localities should set up fatality review teams, a crucial first step towards keeping child murders from going undetected and unpunished. Individuals can volunteer to be foster parents, child advocates or "court-watchers," monitoring the actions of judges and prosecutors.

It may not be possible to ensure that every child is loved, but it is the hallmark of a civilized society to protect those who are too young or infirm to protect themselves. It is incumbent on Georgia to try. It isn't even doing that.

Child Abuse: Blueprint for Reform

Monday, June 19 — The Atlanta Constitution

"We dump everything into our child welfare and social services network and expect them to solve all the problems. But when it comes time to give them money, we don't do so."

— State Sen. Roy Barnes (D-Mableton)

There could not be a more succinct summing-up of the state's many failures with respect to the victims of child abuse and neglect. It has relegated to a fragmented and underfinanced array of agencies and individuals responsibilities for which it has had little enthusiasm itself — deliberately funneling dollars elsewhere, never asking the consequences of its own neglect.

The outrage with which Mr. Barnes and others greeted this newspaper's revelations of abuse and bureaucratic indifference suggest it was benign neglect. Corrective legislation is already taking shape.

But if it was ignorance rather than indifference, or worse, hostility, to the needs of abused and abandoned children that have kept them from reordering their priorities, the lawmakers have run out of excuses. Reporter Jane O. Hansen's shocking series "Suffer the Children" was not only an indictment of the system set up to protect children, but a blueprint for reform. There is no mystery about what needs to be done.

The General Assembly should:

- Repeal confidentiality statutes that make social workers or medical examiners skittish about sharing information that could save children's lives.
- Set standards for the monitoring and investigation of suspicious deaths.
- Require coroners to have medical training.
- Require judges to appoint child advocates in cases involving abuse or neglect, and broaden the use of videotapes in court.
- Remove obstacles to adoption by single parents.
- Substantially increase allocations for parenting, job training and mental-health assistance for abusive parents.
- Set time limits on "parental rights" to free foster children for adoption.

State Must Try to Protect Youth, Despite Its Limits

Sunday, June 18
Perspective section

By James G. Ledbetter
Special to the Journal-Constitution

The late Vice President Hubert H. Humphrey said, "The moral test of government is how it treats those who are in the dawn of life — the children, those who are in the twilight of life — the aged, and those who are in the shadows of life — the sick, the needy and the handicapped."

In the recent series, "Suffer the Children," Atlanta Journal-Constitution reporter Jane O. Hansen gave us a shattering look at those in the dawn of life — Georgia's children. As the commissioner of the agency in state government charged with protecting children and helping families in crisis, I am saddened by what these stories reveal.

The other sad truth I confront daily is this: The multifaceted problems facing children require more than much of today's governmental structures are capable of delivering. While poverty, child abuse and human suffering are nothing new in human history, we are certainly facing enormous problems today. We are dealing with an epidemic of drug abuse, changes in family groupings, shifting moral values and a violence-saturated culture.

Two examples of how these changes create new demands on the state:

- In an estimated 25 percent of confirmed cases of child abuse, the abuser is a stepparent or boyfriend.
- Nationwide, 35 percent of child maltreatment cases are related to parental drug abuse.

As the human problems have escalated, so have the demands for government to do something. Increasingly, people turn to the state to solve complex human problems. No matter how caring or rich the state may be, it alone cannot stop parents from maltreating their children, cannot stop children from having children, and cannot stop people from shooting drugs into their veins.

While recognizing the limitations of the state, we cannot use this as an excuse to continue to apply yesterday's ointment to today's sores. Our role may be limited by money or the intractability of human beings, but that doesn't mean we are powerless. We, like other states, must continue to grapple with how to do our job better.

For children to be protected, concerned citizens must speak out to their legislators on behalf of those who cannot speak for themselves and demand the services that children deserve. They must exert their political will as strongly for children and families as they have for building more prisons.

State government must change to reflect current realities, and communities must join hands to ensure that children's needs become a priority. We must redirect our focus to prevention rather than simply picking up the pieces. All too often, by the time the state gets involved with a family, great damage has already been done to a child. If more front-end assistance were available to families — services such as affordable day care, job training, parent education — we might not have to remove a child in the first place.

Even a cursory look at the inmates in our prison system should tell us that if we don't pay now as a society, we will pay later. How many inmates were abused by their parents, how many received inadequate education, how many are illiterate? How many were raised by the state — a poor parent at best, and one which may be serving as a feeder for the adult criminal justice system?

Even if we act out of selfish motives — that is, provide early intervention services to families to prevent them from becoming a further burden on the state — this is far better than taking no action at all.

The Georgia Department of Human Resources intends to take the following actions:

1. Request funding for additional child protective and placement services (CPS) workers.
2. Provide longer, more extensive training to CPS workers.
3. Provide longer, more extensive training for foster parents.
4. Reduce caseloads.
5. Request funding for preventive services workers to help at-risk families.
6. Review confidentiality statutes with legislative committees.

> Even if we act out of selfish motives — that is, provide early intervention services to families to prevent them from becoming a further burden on the state — this is far better than taking no action at all.

Finally, child maltreatment reflects each community's problems and calls for concerted community response. Some specific ways that local citizens can get involved in child welfare include:

- Citizen review panels — volunteers who monitor the progress of children in foster care and assist the state with decisions about the child's future.
- Court-appointed special volunteers who serve as advocates for abused and neglected children.
- Child abuse protocol teams — multidisciplinary groups that define the roles of courts, the DHR and law enforcement in investigating child maltreatment reports.

My belief is that change comes about as a result of public demand and involvement. That is why I hope that Ms. Hansen's reporting will be a catalyst to unleash outrage at how poorly our children are served and a public outcry for improvement. I am gratified that citizens are responding in such positive ways — from offering to bring toys to children's shelters, to volunteering, to asking to become foster parents. It will be disappointing — and a terrible message about the value we really place on children — if, when the story is off the front page, we fail to harness the compassion and good will that citizens are showing.

In her recent book describing successful programs for disadvantaged children, Lisbeth Schorr says: "Unshackled from the myth that nothing works, we can mobilize the political will to reduce the number of children hurt by cruel beginnings. By improving the prospects of the least of us, we can assure a more productive, just and civil nation for all of us."

We can. But will we?

James G. Ledbetter is commissioner of the Georgia Department of Human Resources.

LETTERS TO THE EDITOR

June 11-26
The Atlanta Journal-Constitution

When reading the articles of "Suffer the Children," I was filled with disbelief, anger, sadness.

Disbelief, because this society allows its children to be treated like objects of extermination. Anger, because the American judicial system maintains a policy that protects the rights of abusive parents rather than the rights of the innocent. Sadness, because the children who are victims of this physical and mental abuse and lack of family attachment rarely become productive members of our society. Their futures are bleak, and it simply becomes a vicious cycle.

Now that the problem has been exposed, we must do more than feel sad; we must take action.

JACA MARIA WILCOX
Atlanta

Your recent articles concerning abused children, the failure of the foster parent program, and addicted infants invoked many feelings, mainly sadness for the little ones and anger at those responsible. Knowing full well that the problem will probably worsen, are there any answers?

Being the father of a 16-month-old son and having parents in a retirement community has given me an opportunity to see how much joy a child can bring to the elderly and how much love the elderly can give in return. Is there a way to bring these two important segments of our population together for the mutual love and bonding that they both so dearly need?

ED McLAURIN
Marietta

The situations revealed in "Suffer the Children" were unbelievable. It is hard to imagine that such atrocities committed by abusive parents can be virtually ignored by the child-welfare system of this state. The laws concerning child abuse need to be more stringent, and they need to be enforced consistently.

Just as important as protecting the children, and just as important as prosecuting the abusers, the factors which lead parents to abuse their children need to be confronted. The stress of parenting caused by being young and poor could be tackled by lowering the teen pregnancy rate. This can be done through education and an easier accessibility to birth control.

Parents must stand up against the abuse being inflicted by the other person. And society as a whole must take responsibility for what happens to the children. We must support increased funding for the child-welfare system, and support legislators and judges who are advocates for the protection of children.

PAM ROBERDS
Mableton

Never before have I been made aware of the atrocities children live with every day.

Being your average mid-20s "yuppie" (with a real desire to make a difference), I sometimes forget the horrible things that can happen to people.

But you have inspired me to volunteer, and I have already started making calls to find the right place for me to help.

Please keep your commitment to exposing these subjects we can no longer ignore. If you don't do it, who will?

EMILY WOODWARD-MACY
Mableton

As a caseworker in the foster-care unit in DeKalb County, I feel it is crucial that the crisis in child welfare be acknowledged and accepted as a community concern and not just the problem of overburdened and underfinanced public agencies.

If readers focus as much attention on the series's suggestions for public support as on the tragic but true cases reported, the devaluation of children by this society can be ended. How can we justify spending billions on strategic arms when our children remain defenseless?

"Suffer the Children" will be successful if the public outrage generated can be transformed into community involvement and judicial and legislative reform.

LUCI AVERY
Decatur

While I claim to speak for no one else, I suspect there are countless others who share the frustrations, anger, guilt and even shame at being part of a system that is inherently designed to fail the very ones it is purported to protect — abused and neglected children.

As teachers, child-care workers, health professionals and others have the task of reporting suspected cases of abuse, one can only wonder where it will all lead.

While most of us do the best we can with the resources available, it lends little comfort to those with broken bodies, broken hearts and broken spirits. Sadly, the plight of abused and neglected children in Georgia most probably represents a too-common picture of what is typical in this country.

LEE RIDGES-HORTON
East Point

I was appalled and heartbroken by the series on child welfare in Georgia. As I sat reading the articles, I was outraged at the fate of the children languishing in shelters. I was particularly frustrated to learn of the limited resources, both public and private, that are available to assist these children.

I would like to commend the emotionally brave women and men who struggle daily to cope with the scores of abused and neglected helpless children of our society.

DIANE D. MURPHY
Riverdale

I hope the "Suffer the Children" series touched the hearts of all your readers as deeply as it touched mine.

Ironically, stories ran simultaneously with the series concerning the unanimous approval of the Georgia Dome and the opening of Underground Atlanta. A total of $210 million will be spent to provide a beautiful new home for the Falcons. Approximately $142 million was spent on Underground Atlanta, a luxurious facility for dining, dancing, shopping and entertainment. Imagine, more than $350 million spent just to have a good time. The neglected and abused children should be so lucky.

PHYLLIS LINDEBORG
Atlanta

The Medical Association of Georgia especially applauds Jane O. Hansen for calling attention to Georgia's outdated coroner system, which has allowed suspicious deaths of abused children to go undetected or unreported.

Because our state does not require county coroners to possess medical training, or even to consult with a physician in determining a victim's cause of death, a number of probable child-abuse fatalities have been incorrectly, shockingly, attributed to sudden infant death syndrome or other natural causes.

We want to see this practice stopped through reform of our coroner system.

JOE L. NETTLES
President
Medical Association of Georgia
Atlanta

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EXHIBIT IV

JANE O. HANSEN, 39, researched and wrote "Suffer The Children" over a period of six months. Ms. Hansen reports on children's issues for The Atlanta Journal-Constitution and has been a staff member since 1982. She graduated from the Columbia University Graduate School of Journalism that year after serving in the Carter White House, preparing issue briefings for the president's appearances away from Washington.

"Suffer The Children" was supervised by special projects editor Hyde Post and copyedited by Sharon Bailey. Staff writer Ron Taylor assisted in the editing. Photo coverage was coordinated by Rich Addicks, and layouts were designed by Paul Shea, news editor for special projects.

JUDICIAL DECISIONS

Cited in Penaranda v. Cato, 740 F. Supp. 1578 (S.D. Ga. 1990).

ARTICLE 2

CHILD ABUSE AND DEPRIVATION RECORDS

49-5-40. Definitions; confidentiality of records; restricted access to records.

Editor's notes. — Ga. L. 1991, p. 1320, § 5, effective April 16, 1991, repeals Ga. L. 1990, p. 1778, § 5, which read: "This Act shall not authorize or require the inspection of any records or the release of any information if that inspection or release would result in the loss of any federal funds to the state", and appears as an editor's note under this Code section in the bound volume.

49-5-41. Persons and agencies permitted access to records.

(a) Notwithstanding Code Section 49-5-40, the following persons or agencies shall have reasonable access to such records concerning reports of child abuse:

(1) A legally mandated, public or private, child protective agency of this state or any other state bound by similar confidentiality provisions and requirements which is investigating a report of known or suspected child abuse or treating a child or family which is the subject of a report or record;

(2) A court, by subpoena, upon its finding that access to such records may be necessary for determination of an issue before such court; provided, however, that the court shall examine such record in camera, unless the court determines that public disclosure of the information contained therein is necessary for the resolution of an issue then before it and the record is otherwise admissible under the rules of evidence;

(3) A grand jury by subpoena upon its determination that access to such records is necessary in the conduct of its official business;

(4) A district attorney of any judicial circuit in this state or any assistant district attorney who may seek such access in connection with official duty;

(5) Any adult who makes a report of suspected child abuse as required by Code Section 19-7-5, but such access shall include only notification regarding the child concerning whom the report was made, shall disclose only whether the investigation by the department or governmental child protective agency of the reported abuse is ongoing or completed and, if completed, whether child abuse was confirmed or unconfirmed, and shall only be disclosed if requested by the person making the report;

(6) Any adult requesting information regarding investigations by the department or a governmental child protective agency regarding a deceased child when such person specifies the identity of the child, but such access shall be limited to a disclosure regarding whether there is such an ongoing or completed investigation of such death and, if completed, whether child abuse was confirmed or unconfirmed; and

(7) The State Personnel Board, by administrative subpoena, upon a finding by a State Personnel Board administrative hearing officer that access to such records may be necessary for a determination of an issue involving departmental personnel and that issue involves the conduct of such personnel in child related employment activities, provided that only those parts of the record relevant to the child related employment activities shall be disclosed. The name of any complainant or client shall not be identified or entered into the record.

(b) (1) Notwithstanding Code Section 49-5-40, the juvenile court in the county in which are located any department or county board records concerning reports of child abuse, after application for inspection and a hearing on the issue, shall permit inspection of such records by or release of information from such records to individuals or entities who are engaged in legitimate research for educational, scientific, or public purposes and who comply with the provisions of this subsection. When those records are located in more than one county, the application may be made to the juvenile court of any one such county. A copy of any application authorized by this subsection shall be served on the nearest office of the department. In cases where the location of the records is unknown to the applicant, the application may be made to the Juvenile Court of Fulton County.

(2) The juvenile court to which an application is made pursuant to paragraph (1) of this subsection shall not grant the application unless:

(A) The application includes a description of the proposed research project, including a specific statement of the information required, the purpose for which the project requires that information, and a methodology to assure the information is not arbitrarily sought;

(B) The applicant carries the burden of showing the legitimacy of the research project; and

(C) Names and addresses of individuals, other than officials, employees, or agents of agencies receiving or investigating a report of

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abuse or treating a child or family which is the subject of a report, shall be deleted from any information released pursuant to this subsection unless the court determines that having the names and addresses open for review is essential to the research and the child, through his or her representative, gives permission to release the information.

(3) Notwithstanding the provisions of this subsection, access to the child abuse registry created pursuant to Article 8 of this chapter shall not be permitted except as allowed by Article 8 of this chapter.

(c) The department or a county or other state or local agency may permit access to records concerning reports of child abuse and may release information from such records to the following persons or agencies when deemed appropriate by such department:

(1) A physician who has before him a child whom he reasonably suspects may be abused;

(2) Police or any other law enforcement agency of this state or any other state or any medical examiner or coroner investigating a report of known or suspected child abuse;

(3) A person legally authorized to place a child in protective custody when such person has before him a child he reasonably suspects may be abused and such person requires the information in the record or report in order to determine whether to place the child in protective custody;

(4) An agency or person having the legal custody, responsibility, or authorization to care for, treat, or supervise the child who is the subject of a report or record;

(5) An agency, facility, or person having responsibility or authorization to assist in making a judicial determination for the child who is the subject of the report or record of child abuse, including but not limited to members of officially recognized citizen review panels, court appointed guardians ad litem, certified Court Appointed Special Advocate (CASA) volunteers who are appointed by a judge of a juvenile court to act as advocates for the best interest of a child in a juvenile proceeding, and members of a county child abuse protocol committee or task force;

(6) A legally mandated public child protective agency or law enforcement agency of another state bound by similar confidentiality provisions and requirements when, during or following the department's investigation of a report of child abuse, the alleged abuser has left this state;

(7) A child welfare agency, as defined in Code Section 49-5-12, or a school where the department has investigated allegations of child abuse made against any employee of such agency or school and any child remains at risk from exposure to that employee, except that such access or release shall protect the identity of:

(A) Any person reporting the child abuse; and

(B) Any other person whose life or safety has been determined by the department or agency likely to be endangered if the identity were not so protected;

(8) An employee of a school or employee of a child welfare agency, as defined in Code Section 49-5-12, against whom allegations of child abuse have been made, when the department has been unable to determine the extent of the employee's involvement in alleged child abuse against any child in the care of that school or agency. In those instances, upon receiving a request and signed release from the employee, the department may report its findings to the employer, except that such access or release shall protect the identity of:

(A) Any person reporting the child abuse; and

(B) Any other person whose life or safety has been determined by the department or agency likely to be endangered if the identity were not so protected; and

(9) Any person who has an ongoing relationship with the child named in the record or report of child abuse any part of which is to be disclosed to such person but only if that person is required to report suspected abuse of that child pursuant to subsection (b) of Code Section 19-7-5, as that subsection existed on January 1, 1990. (Ga. L. 1975, p. 1135, § 2; Ga. L. 1990, p. 1778, § 2; Ga. L. 1991, p. 1320, §§ 1-3.)

The 1991 amendment, effective April 16, 1991, in the first sentence of paragraph (7) of subsection (a), inserted "and that issue involves the conduct of such personnel in child related employment activities" and substituted "child related employment activities" for "personnel action" near the end, rewrote subparagraph (b)(2)(C), deleted former paragraph (3) of subsection (b), relating to failure to conduct a research project in accordance with the research application, and redesignated former paragraph (4) as paragraph (3) of subsection (b); in paragraph (7) of subsection (c), added the language beginning with ", except that" and added subparagraphs (A) and (B), and in paragraph (8) of subsection (c), added the language beginning with ", except that" and added subparagraphs (A) and (B).

Editor's notes. — Ga. L. 1991, p. 1320, § 5, effective April 16, 1991, repeals Ga. L. 1990, p. 1778, § 5, which read "This Act shall not authorize or require the inspection of any records or the release of any information if that inspection or release would result in the loss of any federal funds to the state", and appears as an editor's note under this Code section in the bound volume.

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EXHIBIT V

House of Representatives

Atlanta, Georgia

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COMMITTEES:
INDUSTRIAL RELATIONS
JUDICIARY
TRANSPORTATION

September 12, 1991

The Honorable Wyche Fowler
c/o Chris Schepis
10 Park Place South
Suite 501
Atlanta, Georgia 30303

Dear Wyche:

I need to bring to your attention some continuing problems the State of Georgia is having with current federal Department of Health and Human Services in relation to confidentiality regulations governing child abuse reports.

As I am sure you are aware, there has been a great deal of state public attention to Georgia's Department of Family and Children Services management of child abuse records, and the confidentiality of said records in relation to deceased children. Jane Hanson's article "Suffer the Children" concluded that confidentiality regulations were used by the State, not to protect children, but to protect the bureaucracy.

Following her articles, and following extensive hearings conducted in 1989 by the Joint House-Senate Study Committee on child protection issues, which I co-chaired, eight bills were introduced and passed in the 1990 General Assembly Session, including House Bill 1319, which amended Georgia's confidentiality statute. The federal HHS oversight attorneys have questioned the compliance of our House Bill 1319, and House Bill 289, passed in the 1991 Session, which amended confidentiality provisions of Chapter 5, Title 49 of the Georgia Code.

The Honorable Wyche Fowler
September 12, 1991
Page Two

It is my clear opinion that federal regulations in relation to confidentiality of child abuse records are internally inconsistent, and ineptly drafted in relation to the goal of protecting children. In the attached correspondence I offer for your review, it is clear that HHS is contending the confidentiality regulations apply to children who are deceased. What possible interest could a dead child have in the records being confidential? Rather, the confidentiality in such a case is clearly only used for the benefit of someone other than the child. To the extent that that deceased child had siblings who were still subject to state scrutiny and supervision, we made protections and provisions for confidentiality.

I am very frustrated that I continue to use my time and energy to referee a dispute between the federal government and federal and state bureaucrats in relation to confidentiality interpretations. The Georgia Press Association is constantly in the General Assembly advocating for more openness. I personally believe that more openness of the state's treatment of abused children, with the protections and the law in relation to non-identity of individual children and protection of their families, is an important social policy. The federal government, HHS, and its interpretation of Georgia's new confidentiality statutes, is only serving to hold back progress in protecting abused children.

I am attaching for your consideration the most recent documents I have received in relation to HHS inquiry of the state's statutes that were passed in the 1990-1991 General Assembly that I authored. I would appreciate any assistance you may be able to provide in this area.

Thank you.

Cordially,

Mary Margaret Oliver

MMO:nr
Enclosures

cc: Doug Greenwell
Valerie Hepburn
Deborah Elovich
Jane Hanson
Peter Canfield
Barbara Levitas
Lydia Jackson
Georgia Council on Child Abuse

Jane Hansen

How will we know of kids' silent pain?

Jeannie was 9 when her school teacher first noticed something was wrong. The child smelled bad, often came to school hungry and eventually confided she was worried about her 6-year-old sister, Charlene, also dirty and unfed. Jeannie worried, she told the teacher, because her mother partied with men who scared her.

Jeannie asked the teacher for help, and that Blairsville teacher did her best. For more than a year, the woman called the local child welfare department to say she believed these children were living in danger. As Jeannie's concerns grew and nothing seemed to be happening, the teacher would call the department and ask what they were doing in response. "I'm sorry," they would tell her. "We cannot tell you because of confidentiality." We cannot tell you whether the child exists.

Jeannie didn't exist for long. Eventually one of those men who scared her also raped her, stabbed her and dumped her into the river, all as her little sister watched.

As the teacher told this story two years ago to a roomful of Georgia legislators, I thought how incredible it was that I'd never heard or read about the murder of Jeannie. That no one had heard of this child until she was dead.

We hear of the children that die

But no one ever hears of these children until they are dead. And now the federal government doesn't want us to hear about them ever.

After that Blairsville teacher told her story, after legislators had heard enough of such stories, they relaxed the code of confidentiality because, in the words of then Lt. Gov. Zell Miller, "this secrecy in some instances does more harm than good."

They fixed the law so child welfare workers could tell someone like that teacher what action they were taking, so she could be part of the protective net surrounding a child. And they agreed that when a child dies suspiciously, you or I have the right to ask whether anyone ever investigated for child abuse. And if so, what did they find? And if they found abuse, is anyone bringing criminal charges? The idea here was to infuse a little accountability into a system immune from it.

Now the federal government says that new Georgia law goes too far. In a remarkable debate — remarkable in its bureaucratic nitpicking — the federal government announced late last week that it will cut off more than $750,000 in child abuse funds to Georgia if the confidentiality statute isn't tightened back up. Cut off the funds used to train the child protective services workers who make life and death decisions in children's lives. The funds that will pay for the state's first computerized system to track child abusers. The funds that will pay for the state's new fatality review teams that are finally beginning to investigate suspicious children's deaths.

Confidentiality takes life of its own

All because the feds don't think you or I should ask about the circumstances surrounding a child's death. A child whose own parent may have contributed to her death. A child who has no one but us to care and demand that government do a better job.

Confidentiality was intended to protect families' privacy and safeguard the anonymity of those reporting abuse. But it's taken on a life of its own, surrounding the system in a shroud of secrecy that allows government to operate undetected and without accountability.

Privacy rights, the feds now tell us, extend to dead children as well as live ones. Fortunately, Attorney General Mike Bowers and Commissioner of Human Resources Jim Ledbetter and Ga. Rep. Mary Margaret Oliver seem to be digging in their heels on this one. After all, whose privacy is being protected here? Certainly not the child's. The child is dead. The parents? They may be responsible for the death.

"Rather the confidentiality in such a case is clearly only used for the benefit of someone other than the child," Ms. Oliver wrote last week to U.S. Sen. Wyche Fowler in a request for help.

Jeannie died at the hands of a man who frightened her. But her death could have been prevented. She died here in Georgia, unheralded and forgotten, because the system failed her. Because we never asked why, until it was too late. Because we just didn't know.

THE ATLANTA CONSTITUTION

★★★★★ TUESDAY, SEPTEMBER 24, 1991

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United States Senate
COMMITTEE ON ARMED SERVICES
WASHINGTON, DC 20510-6050

September 27, 1991

The Honorable Louis W. Sullivan
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Louis:

I would like to bring to your attention my deep concern over the on-going dispute involving the State of Georgia and the U.S. Department of Health and Human Services (HHS) regarding the confidentiality of child abuse records.

As you may know, the Georgia General Assembly passed legislation in its 1991 session which would ease the confidentiality regulations governing child abuse reports. The Region IV office of HHS concluded last week that two of the recently-passed confidentiality laws were not in compliance with HHS regulations governing the use of federal child abuse prevention funds currently used by the state.

Louis, I believe we both agree that protecting the children is the foremost purpose of child abuse laws. However, it seems clear that tighter confidentiality laws may not be serving the interests and safety of abused children, which is the objective of the federal program in question. Furthermore, it appears that the HHS regulations involved in this dispute are being interpreted inconsistently at different times in different places.

I encourage you to read the enclosed article from Tuesday's Atlanta Constitution which describes the grave implications of this ruling in Georgia. In addition, I have enclosed a letter and certain relevent attachments from State Rep. Mary Margaret Oliver to Senator Fowler which further explain this matter.

I look forward to hearing your views on this matter.

Sincerely,

Sam

Sam Nunn

Enclosures

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 17 1991

The Honorable Sam Nunn
United States Senate
Washington, D.C. 20510-6050

Dear Sam:

This is in response to your letter expressing concern regarding a conflict between Georgia statutes and Federal regulations with respect to the disclosure of confidential information contained in child abuse and neglect records.

In order to be eligible for a Basic State Grant under the Child Abuse Prevention and Treatment Act (the Act), a State must, among other things, provide for methods to preserve the confidentiality of all records in order to protect the rights of the child and the child's parents or guardians (42 U.S.C. Section 5106a(b)(4)). The Department of Health and Human Services' (the Department) implementing regulations at 45 C.F.R. Section 1340.14(i) permit States to authorize disclosure of reports and records concerning child abuse or neglect to several categories of persons and agencies. A copy of the regulation is enclosed.

The issue with respect to Georgia concerned Section 49-5-41(a)(6) of Chapter 5 of Title 49 of the Official Code of Georgia Annotated which permits release of information about the status and results of an investigation to "[a]ny adult requesting information regarding investigations by the department or a governmental child protective agency regarding a deceased child when such person specifies the identity of the child." The Federal regulations do not provide for such disclosure.

The issues raised by this provision of the Georgia law are not limited to the preservation of the privacy of a deceased child. The Federal Act requires that a State provide methods to preserve the confidentiality of all records in order to protect not only the rights of the child but also the rights of the child's parents or guardians, including their right to privacy. By permitting the release of information to any adult merely on the basis of that person's ability to provide the name of a deceased child, that provision of the Georgia statute does not provide the safeguards required by the Federal Act and regulations.

We understand that this provision was enacted by the Georgia General Assembly in an effort to respond to criticism that the State used the confidentiality provisions to block investigations by the media into the State's handling of child abuse and neglect cases. However, the Federal regulations do not authorize States to permit such broad access to child abuse and neglect records. We believe that the confidentiality requirements of the Act are clearly intended to protect children and their families from indiscriminate disclosure of information and that the Department's regulations implementing those requirements continue to be appropriate. Moreover, the regulations do permit disclosure for law enforcement purposes and to State officials with oversight functions.

The conflict between the Georgia statutes and the Federal requirements was resolved when the Director of the Georgia Division of Family and Children Services invoked a statutory savings clause that allowed the State to follow its prior policy, thereby complying with Federal requirements.

I appreciate your interest in this program. I want to assure you that the Department is committed to assisting the State of Georgia in its efforts to improve and strengthen child abuse and neglect prevention and treatment programs. Please also be assured that the Department is attempting to administer its confidentiality regulations, on a national basis, as fairly and uniformly as possible. A similar letter has been sent to Senator Wyche Fowler, Jr.

Sincerely,

Lou

Louis W. Sullivan, M.D.

Enclosure

Chairman **Owens**. Thank you.

I want to thank you in particular for doing a tremendous amount of work that can be very useful to us. My staff will take a very close look at this and make it a high priority, I assure you. We do appreciate it.

I also would understand if you have to leave before we continue. There is a vote on now, and I'll have to recess for a few minutes. All of you have waited patiently. I hope you don't mind waiting for a little while longer when I return to complete the hearing.

[Recess.]

Chairman **Owens**. Please take your seats.

Again, we'd like to thank the members of Panel Three for waiting so patiently.

Dr. Susan Wells.

Ms. **Wells**. Thank you, and good afternoon.

I am Susan Wells, Director of Research for the American Bar Association's Center on Children and the Law.

My testimony today relates to a project we had that was funded by the Robert Wood Johnson Foundation, conducted in cooperation with the American Academy of Pediatrics. This project was funded in 1989 to help States and localities in their response to child fatalities.

The views I express today, however, are my own, and result from 20 years' experience in child welfare, starting back in 1972, as a child welfare worker. They do not represent the policies of the American Bar Association or the American Academy of Pediatrics.

As a result of inter-agency involvement, child death review teams serve multiple purposes that are in the public interest. Locally, they protect surviving children remaining in the home and seek to track deaths to protect any future unborn children in the family. In addition, at the local and State levels, teams are used to hold agencies accountable for the services that they provide.

Finally, the team also serves the common good through its public health mission. By gathering data regarding occurrence, causes, and circumstances of child deaths, the aggregated data over time will point the way to new prevention efforts.

The success of these teams hinges on the cooperation between the participating agencies, and I know this is something we've talked a lot about today.

To this end, it is imperative that the members of the inter-agency teams have the freedom to share information with one another; that teachers, that social workers, that medical personnel all be active members of the teams and be able to share information. This can only occur, I think, if that information is safe from persons outside the team.

To protect that information, we have drafted some sample legislation. My colleague, Sarah Kaplan, who is with me today, has made at least two recommendations: one, that teams not be regarded as open public meetings; and two, that identifying information about children and families not be released to the public in any circumstances.

Although these provisions are not entirely popular, they are necessary to maintain the integrity of team functioning. The right to privacy is fundamental in ensuring treatment, for example, in drug treatment, alcohol treatment, not to mention child abuse and neglect.

In addition, the variability of the child protective service agency to protect children rests on their ability to maintain confidential records over time. If these records are not confidential, their very existence may be threatened.

These provisions do not prohibit team members from gaining the same information discussed in the team in the ordinary course of their investigative duties. In addition, once an arrest has been made, all legislation pertaining to public nature of arrest and trial records will prevail, with reference to the information collected by law enforcement or the prosecuting attorney.

Likewise, depending on the State, birth certificates, death certificates, and results of medical examiner coroner investigations are commonly public records.

Ensuring accountability of public agencies does not arise from holding them to account on individual cases, no matter how vivid or shocking. Rather, it follows from a systematic accumulation of data over time that indicates how agencies are functioning, who they are serving, the degree to which they are meeting their mandates.

This data informs us only in the aggregate over many cases, over time. Child protective services is one of the few positions of public responsibility in this country that can rise and fall on the public report of one case, no matter how that agency has functioned for thousands of other children served.

To protect against the politicization of protective services, it is critical to institute mechanisms of quality assurance, mechanisms of accountability and sound management, and to put leadership in the hands of those most well trained to do the job, rather than those with the best connections.

Every election year all over this country, child protective service agencies dismantle and reorganize their structures, their goals, and their methods because a new governor is elected.

Our recommendations, therefore, are twofold. First, I'd like to review what could be done at the State level to respond more effectively to child fatalities; and second, I'd like to address the methods by which the members of the subcommittee may serve these purposes.

First, each State should develop plans for response to child death; for example, regarding the conduct of investigation, inter-agency notification, mandatory autopsies—a critical issue, and services to surviving children in the home.

Further, in conducting coordinated investigations, treatment planning and review, inter-agency teams should be allowed immediate access to all agency records pertaining to the case including, for example, mental health, medical, child protective services, coroner and medical examiner's findings. It's amazing how much this varies from State to State.

In one State, I actually heard a medical examiner say that his records—that he couldn't release information, which in many States is commonly public.

The wording should not limit the agencies which may share information. In addition, there should be no release of identifying information discussed in the team to persons outside the team.

At the Federal level, legislators should review Federal legislation regarding access records; for example, drug and alcohol legislation, educational legislation. Confidentiality and child abuse and neglect, I don't think, is the biggest problem in these teams, because there is some permission in the regulation to share this information and to pull together multi-disciplinary teams.

But there is other Federal legislation which impacts on people's ability to share information, and to cooperate with the teams.

In addition—I think it would perhaps not be in the purview of this subcommittee—we have to look at the coroner and medical examiner system in this country. I think it is not centrally organized and in a bit of a shambles.

Additional funding should be provided to States to provide training at the local level, to enhance coordinated investigation systems with specific reference to child fatalities and child abuse and neglect in general. Many problems in the child welfare system result from the broad public mandate to protect all children, without requisite funds to support the mandate.

Any additional requirements of the State and local agencies must be supported by funding. To mandate without funding makes the dollar just even that much less.

The National Center on Child Abuse and Neglect and the Administration for Children and Families should take a leadership role in evaluating, mandating, and facilitating the enhancement of management of child protective services nationally.

While many system problems may result from lack of funding, there is another problem, and the problem is one of management. We need more effective systems of accountability.

So, if you are going to talk about, for example, the problem of too much paperwork, the issue—it's important not to throw the baby out with the bath water. It's important that agencies be accountable for the work that they do, the children they serve, and how they do it.

I think what we are lacking is sufficient use of technology in human services, so that a worker doesn't have to sit down and fill out 15 forms. If they enter a client's name once, it should be entered everywhere. A computer can do that. It's not that hard. So I think there are steps that we can take to maintain the information and to reduce the paperwork.

Then the recommendations for the subcommittee would be to facilitate team development by reviewing not only the Child Abuse Prevention and Treatment Act, but also other Federal legislation and regulations pertaining to permission to share information for the purposes of supporting investigation, treatment, and review.

Support any additional mandates in Federal legislation with corresponding funding. Ease the burden of funding State and local efforts through examining funding streams of the variety of Federal agencies which deal with abuse and neglect, and facilitate cooperative inter-agency funding of projects at the Federal level.

I can tell you anecdotally that the Inter-Agency Task Force on Child Abuse and Neglect is really undertaking some massive work.

They are tasking themselves to look more closely at how they can cooperate in dealing with child abuse and neglect, but there is no funding attached to this.

So every time you turn, for example, to an agency such as the Center for Disease Control and say, now, you should be responsible for keeping the data. It makes perfect sense that they should for example in child deaths, keep a national death registry. I'm all for it. I'm trying to work on that myself.

The problem is that if they don't have the additional funding to do it, it just becomes one more thing they have to do, and they have to determine where they are going to make their priorities.

Sometimes, by creating joint funding streams, we can cooperate—we can accomplish a lot with a little bit of money from several agencies. To ensure increased agency responsibility, target agency management, quality assurance, ongoing state-of-the-art program evaluation and public reporting of these findings.

In closing, I'd like to encourage the members of the subcommittee and the public in general to use the vivid, dramatic, and important work of the media in a way that will be enabling to those who are charged with the protection of our children.

Rather than allowing public accusation of persons not yet accorded due process of law, focus instead on holding agencies accountable through the entirety of their work. One mechanism through which this may be promoted is child death review teams. Thank you for asking me to speak here today.

[The prepared statement of Susan Wells, Ph.D. follows:]

AMERICAN BAR ASSOCIATION
GOVERNMENTAL AFFAIRS OFFICE • 1800 M STREET, N.W. • WASHINGTON, D.C. 20036 • (202) 331-2200

STATEMENT

OF

Susan J. Wells, Ph.D.
Director of Research
American Bar Association
Center on Children and the Law

BEFORE THE
SUBCOMMITTEE ON SELECT EDUCATION
COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

CONCERNING THE
CHILD ABUSE PREVENTION, ADOPTION, AND FAMILY SERVICES ACT

February 27, 1992

Mister Chairman and Members of the Subcommittee: I am Susan Wells, Director of Research for the American Bar Association's Center on Children and the Law. The Center is a program of the ABA's Young Lawyers Division and has worked on behalf of children since 1978. My testimony today relates to my work as director of a Robert Wood Johnson Foundation project conducted by the Center in cooperation with the American Academy of Pediatrics. This project was funded in 1989 to offer technical assistance to states and localities to aid them in more effectively responding to, and ultimately preventing, child maltreatment fatalities. The views I express are my own and result from twenty years experience in the field of child welfare, beginning as a child welfare worker in 1972. My comments do not represent the official policies of the American Bar Association or the American Academy of Pediatrics.

Child maltreatment fatalities have become the center of increasing public concern in recent years. Child deaths due to abuse and neglect are dramatic reminders to all of us of the horror that many children experience every day, and are defenseless to prevent. Recent reports have suggested alarming increases in homicide statistics in some age groups. For example, according to a January article in USA Today, FBI statistics on homicides of children under the age of one have doubled since 1973 (from 134 in 1973 to 264 in 1990).[1] Yet, these numbers tell only one small part of the story. In a recent study by Dr.s Kivlahan and Ewigman of 360 injury deaths in Missouri from 1983-1986, the authors reported that, while official statistics attributed 29 percent of the injury deaths to child abuse and neglect, intensive record reviews revealed that the actual percentage attributable to child maltreatment was 62 percent.[2] A study of all child deaths in Massachusetts in 1985 revealed, similarly, that deaths attributable to injury, and particularly those due to homicide, were undercounted.[3] These findings are also repeated in other studies.[4]

Undercounting of child maltreatment fatalities is a critical problem. We do not know how many children actually die from abuse and neglect each year, nor do we know the actual circumstances of many of these deaths. As a result, our prevention efforts are bound to be less than adequate. The problems that impede our recognition of child maltreatment deaths include, for example, problems in: 1) accuracy of original diagnoses of the child's condition; 2) absence of autopsies; 3) lack of sufficient autopsy; 4) lack of death scene investigations and 5) lack of coordination in investigation. To give just one example, a 1990 survey of child protective services in the United States conducted by our project revealed that 59 percent of the responding states (42 out of 51 potential respondents, including the District of Columbia) had only informal policies or procedures for coordinating child abuse investigations. Further, in a recent community survey regarding response to reports of child abuse and neglect, many respondents were not aware of the written agreements that did exist.

Child death review teams have been established across the country to more effectively deal with the tragedy of child deaths. The widespread interest in these teams was preceded by the establishment of the Los Angeles County Death Review Team in 1979 and by the thorough work in New York City (funded, in part, by the National Center on Child Abuse and Neglect) and Texas in the early 1980's. These projects sought to more accurately record and report the number of children who were dying, the circumstances of their deaths, and the ways in which the community, including child protective services, could more effectively respond to, and prevent, tragedy.

Child death review committees are formed for a variety of purposes. Some focus on identifying breakdowns in agency services designed to protect children, while others seek to more effectively determine the cause of suspicious deaths and accurately identify those due to maltreatment. Ideally, child death review teams will more accurately identify: 1) causes of death for children under 18; 2) circumstances surrounding, and contributing to, preventable deaths; and 3) needed changes in legislation, policy and practice. Through achieving these objectives, the teams will work toward establishing preventive and interventive mechanisms that will reduce child fatalities.

Our 1991 survey of child death review teams yielded 48 responses from the states and the District of Columbia.[3] Of those responding, only 17 states reported that they had death review teams that meet regularly at the state level. Sixteen states also reported local teams which meet regularly. Of the states which reported teams that meet regularly to review child deaths, three are supported by legislation mandating child death review teams. Since the survey was conducted, at least three other states have also passed legislation mandating child death review teams. The six states which currently have legislation mandating teams are: Georgia, Minnesota, Missouri, North Carolina, Oklahoma and Oregon.

Child death review teams may be organized locally or on the state level. Some teams meet regularly, while others convene as needed. On both the state and local level, there are two major models of fatality review committees: intra-agency and inter/multi-agency. Intra-agency committees, which may also be multi-disciplinary, are often formed primarily for internal review purposes. They usually are composed of representatives from the various units within the agency providing services to families with children. While these committees can be quite effective in identifying and prescribing solutions for problems in one agency, their utility is obviously limited to that one agency. Inter-agency problems, such as a lack of effective coordination and duplication of efforts, cannot be addressed through teams of this type.

Inter-agency, multi-disciplinary death review committees have a broader structure and purpose. At a minimum, these committees usually include representatives from the following agencies: child welfare/child protective services (CPS); law enforcement; public health; medical examiner/coroner; a pediatrician or forensic pathologist; and the local prosecutor. Additional members may include representatives of the school system, probation/parole, SIDS groups, mental health, and others. Some teams also include representatives from the governor's office or a standing legislative committee concerned with children. This often facilitates the introduction of new legislation or policy to improve system responsiveness.

Of the 17 states reporting state teams which meet regularly, only 10 included members from more than one agency. Thirteen states also reported at least one locality in their state that had inter-agency teams which meet regularly to review child deaths. Since the survey was conducted, several other states have passed legislation, issued executive orders, or met to form state death review teams. These include, for example, Missouri, New Hampshire, North Carolina, and Oklahoma.

State teams commonly review systemic problems, make recommendations regarding needed policy or legislative changes, and attempt to promote better communication among agencies in the child protective system. (This may include both public and private agencies.) They may review all child deaths or only selected deaths, but they often do their work retrospectively. That is, they may systematically conduct the review several months after the death (e.g., Colorado reviews cases six months later) in order to ensure that as much information as possible is available and that the investigation has been completed. These retrospective reviews serve two major purposes. One is to accumulate complete data over time which will identify trends in cause of death and further inform preventive efforts. The other is to better evaluate the involvement of all community agencies in order to identify any gaps or problems in service delivery to children and their families.

Local child death review teams often work prospectively. While this breakdown is not a hard and fast rule, local teams will often meet or teleconference within 24 hours of a child's death. Or, they may establish monthly meetings at which they review the deaths of the previous month, keeping in touch by telephone to manage specific issues as they arise. These teams tend to focus on investigative matters and inter-agency coordination. The goals are to ensure that all pertinent information is gathered in the investigation and to ensure that each agency having knowledge of a family contributes to the findings. In addition, local teams may discuss and devise investigation protocols and interagency agreements to address reporting, investigation, and review procedures. Inter-agency access to available information also assists in accurate reporting of fatalities and improved protection of surviving siblings.

As a result of inter-agency involvement, child death review teams serve multiple purposes that are in the public interest. Locally, they protect surviving children remaining in the home and seek to track deaths to protect any future children born to the family. In addition, in some cases they serve law enforcement purposes, ensuring that persons responsible for a child's death be held accountable for it. In addition, at the local and state levels, teams are used to hold agencies accountable for the services they provide. Finally, the team also serves the common good through its public health mission. By gathering data regarding the occurrence, causes, and circumstances of child deaths, the aggregated data, over time, will point the way to new prevention efforts.

While there has not yet been enough time to evaluate the effectiveness of these teams, self reports indicate a great deal of enthusiasm for the degree to which this relatively inexpensive intervention can impact law, policy and practice. These reports are supported by survey findings that indicate that few teams meet less often than originally planned, and many meet more often. The following table lists the results attributable to team functioning as reported in the 50 state survey.

NEW INITIATIVES RESULTING FROM CHILD DEATH REVIEW TEAMS

	ALL TEAMS REPORTED		INTER-AGENCY TEAMS	
	LOCAL N=16	STATE N=17	LOCAL N=13	STATE N=10
New regulations	0	1	0	0
New protocols	4	4	2	3
Other new procedures	0	2	1	1
Improved inter-agency cooperation	9	7	8	5
More accurate i.d. of cause of death	6	5	5	3
More agency intervention with family	4	4	3	2
More prosecution of homicides	2	0	2	0
Legislation	4	2	3	1
Other prevent. efforts	2	1	2	1

The success of these teams hinges on cooperation between the participating agencies. To this end it is imperative that the members of inter-agency teams have the freedom to share information with one another. This can only occur if case specific identifying information shared within the team is protected from release to persons outside the team. Sample legislation resulting from our Child Maltreatment Fatalities Project[6] and drafted by my colleague, Sarah Kaplan, requires that the review team be provided with information that includes but is not limited to: medical, mental health, law enforcement, medical examiner or coroner, parole or probation and protective services information. Where necessary, adjustments to related laws may be made to coincide with the death review team legislation. Another, larger issue however, pertains to the role of Federal legislation and regulations in prohibiting sharing of information. This is true not only for protective services, but also for educational institutions and drug and alcohol treatment centers.

To protect the information once it has been discussed in the meeting, several mechanisms are recommended. The first is that the teams shall be closed to the public and not subject to any open meetings law when individual cases are discussed. In addition, information identifying a deceased child, a family member, guardian or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect may not be publicly disclosed. All information and records acquired by the team in the exercise of its purpose and duties are to be kept confidential and exempt from disclosure. Information that may be released publicly includes statistical compilations of data and reports which do not contain any information that would allow identification of individual cases. Finally, team members are prohibited from disclosing information gained in the team and are protected from questioning in civil or criminal proceedings regarding what has transpired in the team meeting.

While these provisions may appear to be stringent, they are necessary to maintain the integrity of team functioning. What team member would be fully disclosing if he or she expected to see the information in the newspaper the next day? Further, these provisions of the Sample Legislation do not prohibit team members from gaining the same information discussed in the team in the ordinary course of their professional or investigative duties. In addition, once an arrest has been made, all legislation pertaining to the public nature of arrest and trial records will prevail with reference to that information collected by law enforcement or the prosecuting attorney. Likewise, depending on the state, birth certificates, death certificates and results of medical examiner/coroner investigations are commonly public records.

Ensuring accountability of public agencies does not arise from holding them to account on individual cases, no matter how vivid or shocking. Rather, it follows from a systematic accumulation of data over time that indicates how agencies are functioning, who they are serving, and the degree to which they are meeting their mandates. This data informs us only in the aggregate, over many cases and over time. Child protective services is one of the few positions of public responsibility in this country that can rise and fall on the public report of one case, no matter how the agency has functioned for the thousands of other children served. To protect against the politicization of protective services, it is critical to institute mechanisms of quality assurance, mechanisms of accountability and sound management, and to put leadership in the hands of those most well trained to do the job, rather than those with the best connections. Every election year all over this country, child protective services agencies dismantle and reorganize their structures, goals, and methods because a new governor was elected.

Our recommendations, therefore, are two-fold. First, I would like to review what can be done at the state level to respond more effectively to child fatalities. Second, I will address the methods by which the members of the Subcommittee may serve these purposes, either through the Child Abuse Prevention, Adoption and Family Service Act or other federal legislation.

Next Steps in Responding to Child Fatalities:

1) Each state should develop plans for response to child deaths regarding: a) conduct of investigation; b) referrals regarding inter-agency notification, with particular reference to ensuring an investigation by the medical/examiner or coroner in all unexpected or unexplained deaths; c) mandatory autopsies of children under the age of two and preferably under the age of five; d) services to surviving children in the home; and e) the role of the juvenile and family court in protecting surviving children. These plans may include changes in legislation, regulation or agency policy.

2) Further, in conducting coordinated investigations, treatment planning, and review, inter-agency teams should be allowed immediate access to all agency records pertaining to the case, including, for example, mental health, medical, child protective services, coroner's or medical examiner's findings. The wording should not limit the agencies which may share information. In addition, there should be no release of identifying information discussed in the team to persons outside the team.

3) At the federal level, legislators should review federal legislation regarding access to records, e.g., drug and alcohol treatment records and school/educational records. In addition, federal attention should turn to the study of the coroner/medical examiner system nationally, to determine ways in which federal law can impact positively on these systems to ensure appropriate notification, investigation, and the conduct of thorough autopsies.

4) ***Additional funding*** should be provided to the states to provide training at the local level to enhance coordinated investigation systems with specific reference to child fatalities and child abuse and neglect in general. Many problems in the child welfare system result from a broad public mandate to protect all children, without the requisite funds to support the mandate. Any additional requirements of the state and local agencies must be supported by funding.

5) The National Center on Child Abuse and Neglect and the Administration for Children and Families should take a leadership role in evaluating, mandating and facilitating the enhancement of management of child protective service agencies nationally. While, as noted above, many system problems result from insufficient funds to meet the demand for services, at the national, state, and local levels; it is apparent that more effective systems of accountability and management can be instituted. These systems will ensure public accountability and enhance the agency's ability to serve children at risk.

Recommendations for the Subcommittee:

1) Facilitate team development by reviewing not only the Child Abuse Prevention and Treatment Act, but also other federal legislation and regulations pertaining to permission to share information for the purposes of supporting investigation, treatment and review.

2) Support any additional mandates in federal legislation with corresponding additional funding.

3) Ease the burden of funding state and local efforts through examining funding streams of the variety of federal agencies which deal with abuse and neglect and facilitate cooperative inter-agency funding of projects at the federal level.

4) To ensure increased agency responsibility, target agency management, quality assurance, ongoing state-of-the-art program evaluation, and public reporting of these findings.

In closing, I would like to encourage the members of the Subcommittee and the public in general to use the vivid, dramatic and important work of the media in a way that will be enabling to those who are charged with the protection of our children. Rather than allowing public accusation of persons not yet accorded the due process of law, focus instead on holding agencies accountable through the entirety of their work. One mechanism through which this may be promoted is child death review teams.

Thank you for asking me to speak to you today. If there is anything further that I or my colleagues can do to be of assistance, we would be pleased to work with you on this or related topics.

NOTES

1. *USA Today*, January 25, 1992.

2. Task Force on Fatal Child Abuse. 1989. *Final Recommendations of the Department of Social Services' Task Force on Fatal Child Abuse*. Jefferson City, Missouri: Missouri Department of Social Services, Division of Family Services.

3. Sapiro, E. and Lescholier, I. 1989. *Staying Alive..Preventing Child Death: The Massachusetts Child Death Study*. Boston, Massachusetts: Department of Public Health.

4. See for example, Christoffel, K. K. 1990. Violent death and injury in U.S. children and adolescents. *American Journal of Diseases in Children*. 144:697-706; Christoffel, K. K. and Amari, M. 1983. Homicide in childhood. *American Journal of Forensic Medicine and Pathology*. 4:129-137; and Jason, J., Carpenter, M. and Tyler, C. 1983. Underrecording of infant homicide in the United States. *American Journal of Public Health* 73:195-197.

5. The following information on death review teams is derived from: Granik, L., Durfee, M. and Wells, S. *1991. Child Death Review Teams: A Manual for Design and Implementation*. Washington, DC: American Bar Association and Kaplan, S. 1991. *Child Fatality Legislation in the United States*. Washington, DC: American Bar Association.

6. Kaplan, S. R. *Child Fatality Legislation*.

Chairman **Owens**. Thank you.

Representative Oliver, is it an exaggeration for us to begin to make the case for your argument by saying that other children will die if we don't take those steps?

Ms. **Oliver**. I do not believe that's an exaggeration.

Chairman **Owens**. The accountability you are talking about, however, is an accountability of more than just the workers of the Social Services Department. You are really challenging the accountability of the State. Am I correct?

Ms. **Oliver**. That's correct, and the accountability of the taxpayers, also. My challenge is not only to politicians, it's also to the entire society that we live in.

This struggle that we have on a State level to absorb the Federal mandates, to tax our citizens to pay for the Federal mandates without the necessary resources, is causing a difficult, difficult economic debate.

We, as a society, must face the reality that funding of the prevention issues that you heard about today is absolutely critical or we are going to continue to have children die repeatedly while in State custody, while in the State services.

Confidentiality is one of the barriers to greater accountability, and the child fatality review team approach which, in Georgia, we enacted in 1990—we spent a lot of time on that legislative effort talking about the inter-disciplinary exchange of information, and set that out fully in our statutory framework.

These issues very much go together.

Chairman **Owens**. I think all of you were here when Congressman Goodling read the testimony of the first witness. The issues he raised were primarily related to children who were still alive.

Would you say that once the child has died, that those arguments regardless of—we won't get into detail as to how you counter those arguments with better administrative structures—but once a child has died, automatically, most of those considerations go out?

A serious matter has occurred, the child has died, and the threat to disruption of the family and a number of other things he raised are no longer there.

Ms. **Oliver**. That's absolutely correct.

You can look at that question as a policy question in terms of, again, the accountability of the bureaucrats and what our taxpayers must know for them to become involved in the solution.

Or you can look at it more narrowly, sometimes as I do as a lawyer, as who owns the privacy rights of a child who's deceased. I think that is a State by State case law analysis.

We have Georgia case law that says, in effect—that implies in effect—it states almost directly that a decreased child's privacy rights are analyzed very differently than that of a child who is alive.

Chairman **Owens**. Dr. Durfee.

Dr. **Durfee**. If I might add, in some ways, things get worse when a child dies, because agencies that are mandated to protect children say that's no longer our responsibility. We don't protect children who are dead, and unless someone can identify siblings, that's no longer our case.

People that deal with criminal justice issues of homicide say that's not homicide, that was a family problem. It's child abuse. Then the cases are lost at the Federal, State, and local level between the criminal justice and human service issue, each one making some frightening assumptions that the other one is responsible.

It does seem to me that some things change when a child dies. But, it would seem to me to be a sad comment if when a child dies, we then say we can and will talk to each other, but that we require that death before that action.

What I'm seeing with the teams nationally—and there's 50 to 100 teams that I'm following—is they may begin with a fairly narrow focus of fatal child abuse, but the connections that are built in the team then spread on to everything else.

The teams themselves are either doing inspirational work or creating criminal acts, depending on how you want to read the confidentiality statutes.

But I would not want to see us focus on confidentially as being an issue simply for dead children. It is also an issue for children who are alive, and I would agree with Dr. Wells' comments that we need to preserve confidentiality.

I'm a child psychiatrist. I work in public health. We have VD records. There are special records with HIV infections, but I don't think that keeps us from talking to each other. My personal sense is the reason records are not shared is not so much a legal issue. It falls more in my field of child psychiatry.

It has to do with personal anxiety of people who don't want their work to be observed. If they can and do that—and Georgia has been an inspiration to all of us in implementing the program there. They do it very well.

I've been a consultant and been to Georgia several times in implementing the program there, and I'm impressed. If you take most of the people who are on or near the line and hand them a tool, they will work with it.

The major resistance does not come from line staff who don't want their work so public, it comes from middle and senior management. The exceptions are notable with middle and senior management, particularly those who have been on the line and appreciate the dilemma of a worker who has touched and cared for a child and the child is dead, and the worker ends up blaming himself for the rest of his life.

Dr. **Wells**. I would say, though, that it seems that we are talking about two different things here when we talk about confidentiality.

One is the inter-disciplinary cooperation. I think that is absolutely critical, and I don't think you'd find an argument against it here today.

Chairman **Owens**. I was about to raise the question about interdisciplinary cooperation among professions who will be thrown together repeatedly. With the same set of professionals, with no objective outside personnel, is there a danger of cronyism or back scratching and horse trading there? Do you think that there ought to be some way to avoid that?

Dr. **Wells**. I think maybe Dr. Durfee could speak to that.

Dr. **Durfee.** I will tell you that with our team—and it was 1978 when we began—you take some people who feel the pain of the line experience, and there is some cronyism and back scratching that takes place within agencies, within senior management, but the team doesn't do that.

We may move to protect our agencies and associations over a population of problems, but you take an individual dead child, and we have had the experience repeatedly of someone pondering whether their records are secret, and using what is an unfortunate opening, we say that the baby's dead. Are you telling me you are not going to talk to me?

The multi-agency structure interferes with the cronyism. There are some teams, nationally, that will have someone from a child abuse council, child advocate, someone labeled "private citizen." Those teams have made that choice and the team has worked well.

I would not want to encourage the thought that public employees are innately evil, and private citizens are innately noble.

My sense is that the teams that are going to have the most problems with team cooperation are those teams that came from political appointments and people who were put on the teams because they happen to be able to connect to people who are prominent. When those appointments are put in to oversight an agency, they come in, perhaps meaning well, but they, at least occasionally, are more than hazardous.

I think the accountability for the team comes in the reports, and there are reports from L.A. County, Colorado, and Oregon, and we'll be expecting one from North Carolina fairly soon.

Actually, there have been some reports historically from New York City, and some of the work that at that time was very timely in the mid-1980s—those reports can keep an agency accountable in the same way that you can monitor a school with math and reading levels. You don't need to have someone monitoring the classroom video tape to make sure the teacher is behaving.

Ms. **Oliver.** We, in Georgia, have 159 counties. It's way too many. It obviously represents a lot of small communities that are organized, and our child fatality review teams are organized by county.

I want to agree very strongly with Dr. Durfee. People who are on the line—the individual sheriff's officer that had to go into the home and find the body, the individual case worker, the individual teacher—those people in small and medium and large communities have a shared experience, and I believe want to help and work together well.

I strongly believe it is the middle and upper level management, though, the highly paid, staff-protective individuals who are slowing the process down.

Dr. Horn and I spoke briefly as he was leaving. I wanted to challenge him a little bit on some of my positions and theories. He was taking the position in one way with me that, well, the regulations allow all this sharing now.

If it does, if that is accurate, then why do we have a constant, senior level direction of no, you can't; no, you can't; no you can't? Why isn't the affirmative statement going out that you must share, you must enlist that teacher to help, you must enlist that park and recreation supervisor to help you. That affirmative leadership, to expand the team is not being carried out.

I also want to agree with Dr. Wells in connection with the protection of those documents together—the team ethic.

I found that the team ethic works, and that there are rules that you can adopt for those teams about what is shared and what is not to help those individuals who are extremely highly motivated work well together.

Chairman OWENS. Dr. Wells, did I hear you correctly dismiss medical examiners as a group, as not being very efficient?

Dr. WELLS. No, no, no, the system—you've got medical examiners in some States which have marvelous systems. North Carolina has a very admirable medical examiner system.

In other States, you have coroner systems. In some cases, they work very well. The coroners may also be the sheriffs, for example, and they have an investigative capacity and they carry it out in a very orderly fashion.

In other places, they may have no experience of any sort having anything to do with investigation, medicine, or whatever. They are elected or they are chosen.

Chairman OWENS. These people would end up being a part of the team, though, wouldn't they?

Dr. WELLS. Yes, but what I'm saying is, the only reason I brought that up is that the system, nationwide, has no order. It would be very nice if we had a medical examiner system in every State in the country. That would be very nice.

Chairman OWENS. If we had some minimum standards.

Dr. WELLS. That's right.

But I did want to make one other point. I think that our panel member who is not here today might have wanted to add something to this. That's where my concern lies.

That is that, as I was saying earlier, the confidentiality issue is two issues. There is the inter-agency team, which I think is supported.

But the release of identifying information to the public is, I think, not helpful. It is not helpful for people seeking treatment; it is not helpful for the maintenance of confidential child welfare records, much less medical records, drug treatment records. I would be very cautious in thinking along those lines.

Chairman OWENS. You also mentioned technology as being one way to reduce the paperwork. I thought of that early in the day when the testimonies were being given about paperwork.

On the other hand, confidentiality becomes a little more of a problem, unless your experience as a lawyer can tell us that there are systems that have been developed to maintain confidentiality, even when you have computerized records.

Dr. WELLS. I'm sorry, I didn't mean to mislead you. I'm not an attorney. I'm a social worker and a researcher. But I come from the American Bar Association. They believe in multi-disciplinary teams.

Chairman OWENS. All right, in your setting, in your contact with the lawyers, are the lawyers convinced that they have systems which can maintain confidentiality, even when it is computerized?

Dr. **Wells**. The confidentiality thing, I think, is a big issue with computers. As we have seen over the past years, when the Department of Defense computers can be accessed, we have a bit of a problem as far as computer security goes. I think folks are working on that all the time. But I don't think that it is any less perfect at this point than paper. I don't think it is any less secure right now than paper.

Chairman **Owens**. How many States and localities were you able to involve in your project?

Dr. **Wells**. Oh, gee, we had over 20. We have been traveling wonders this year. We have been to Georgia. We have been to North Carolina. That was before I moved down there. We have been to Nebraska, Maine, Arizona, Oklahoma—did we go to Oklahoma—we wrote—we talked to Oklahoma.

Chairman **Owens**. You had a comment?

Ms. **Oliver**. I've also been chairing this session in our General Assembly legislative effort in relation to open records.

We have past due legislation in relation to computer access and confidentiality. All of this is very timely. The States are struggling with this.

I feel that there are tools to manage these new sets of technological problems. It's just a task-oriented, detailed, tedious kind of legislative and policy analysis that you are very familiar with, but it's doable and it's being done.

Chairman **Owens**. I'm always very impressed with the analysis that credit companies give you in great detail at the end of the year. My wife never wants me to see hers.

[Laughter.]

Chairman **Owens**. I yield to Mr. Ballenger for questions.

Mr. **Ballenger**. Thank you, Mr. Chairman, and, again, I apologize to Ms. Oliver and Dr. Durfee for having wasted your time and mine by going over there.

I would like, if I may, to ask the three of you if you heard, first of all, Congressman Goodling's reading of the program by the young lady that couldn't come. Lesley Wimberly, I think, is her name.

There was an area in that discussion that I don't think it had to do with dead children. It had to do with the confidentiality of reporting child abuse where the person that reports it doesn't have to give his name.

In other words, there could be a substantial amount of misuse of the program. I think that's what, when he handed us this sheet here, was the purpose of his question.

I just wondered, in the examination—I realize it's a different ball game when the child is dead. But if the child is living and the family is reported for child abuse, does confidentiality—is it involved in such a way that the accused abuser has really no defense?

Ms. **Oliver**. I'll start. This is a tough set of discussions and issues. I did hear the Congressman, and I'm familiar with the VOCAL group. That's an acronym for a group that's active nationally.

We struggle, on our State level, with a competing set of interests. It's my judgment in looking at these close, difficult policy questions that the reporter of child abuse should never be named.

I think that there is a chilling effect if that reporter of child abuse—we mandate child abuse reporting in Georgia, as they do, I think in every State. Therefore, we mandate that that person act. I think we owe that person confidentiality.

We have just gone to, in part of our package of legislation, computer registration of child abuse investigative reports—how they'll go into the computer, how a person will be entitled to get his name out of the computer, what protections are involved.

As long as we mandate that every child abuse report must be investigated, and that's what we, by State law, mandated, we do spend, I think, approximately 50 percent of our State resources investigating cases that are unfounded or unconfirmed.

I accept that responsibility as someone who levies taxes. I think that we must do that. I think that we can do a better job of it. I think that we can do a quicker, more efficient analysis so that the computer entry is never made that this case is under investigation.

We, in Georgia, say that it will not be entered if it is unfounded. It will be entered in another way if it's unconfirmed. So we are struggling with these issues. We are.

I think, though, that I must support the nonidentity of the informer, one; and two, the mandatory investigation of all calls, even though we know that as a practical matter, many of these calls don't relate to real abuse.

Dr. **Durfee**. Let me disagree a little bit with that last sentence and agree with most of the rest of it.

I don't think we know that most reports do not involve abuse. We get real sloppy with distinguishing between unfounded and unsubstantiated.

The most common response to reported child abuse in California, and I assume nationally, is either to do nothing or make a phone call to someone who is involved with the family or make a single visit with parents or the kids and ask questions.

Cases not being substantiated. It may be that the investigation didn't show anything, but that doesn't mean it wasn't there.

My personal sense is, if we took it on as a project, and we randomly took whatever number of cases we had to take, so that as a group, we decide that 100 of them are mismanaged, we would find a couple of cases that were over-reaction, once the family gets in the system and once you get in, it can be hard to get out.

We may find a couple of cases where people don't like their son-in-law, and so they've made a report to an agency, or in divorce custody cases, people are making allegations about something that has not happened.

But well over 90 percent of the cases will not be mismanaged due to an unnecessary assault on parents. They will be absolutely gloriously and incredibly mismanaged due to an under-reaction to protect children.

This is a very polarized argument. There are fools and poets on both sides. I am a child advocate on my side of the fence. There are people that say children never lie. I am impressed that children most certainly do lie. My children lie. But young children don't lie with the skill that older children do, that adolescents do, that parents do.

But to step on the other side and say, gee, this is interfering in the innately noble institution of the American family and we need to protect that institution; we are out of balance, and our balance is clearly to the side of adults.

It is clearly to the side of affluent adults, and clearly to the side of Caucasian males, or upper middle class with graduate degrees. I am one of them and I find it more than a bit embarrassing.

My oldest son is a real tornado. I've been in and out of the hospital with him, with a series of things, including a basal or skull fracture when he ran a bicycle into a wall. You can take my word for it, I didn't do it. At any rate, he is stronger than I am now.

I am very impressed that my medical colleagues never asked me a question. Some of that had to do with the time. In the 1960s, we didn't know much about child abuse. We were still infatuated with the 1950's television model of a family.

But we do need to pursue the cases. There is not a giant plot against the American family in the industry that is advocating for children. There are fools, but it is not an organized plot.

I personally resent the tone of some of the comments, perhaps including those of the first speaker. That testimony suggests that our dilemma is a failure to protect parents and that we are abusing parents. I don't think that exponentially; our abuse is of children.

Mr. **Ballenger**. If I may, I think if you read her testimony, the young lady's, I think she just said, let's not overdo it. I'm not sure that——

Dr. **Durfee**. I didn't need to go to graduate school to sense the fact that I am not dispassionate at this moment. I may well be overstating things, and I will apologize to whoever wrote that if I have overstated my argument.

Mr. **Ballenger**. No problem. I don't know the lady, so——

Dr. **Durfee**. Well, it is important that I become accurate and objective. I represent something. I need not be foolish and say, forget confidentiality, we've got to protect kids.

I need to play out a very reasoned—what would seem to be a middle ground in these arguments, because somewhat by default, I am a major decision maker in this process. So is Congress.

I think it's historic, if we look at legislation that addresses families. On almost anything, the protection does not go to children. When it does, it does not go to babies. When it does, it does not go to minority poor babies.

Black babies in this country die at more than twice the rate of white babies, from all causes, quite possibly including homicide. I don't think we piece that out. To ignore that is a comment on our failure to concern ourselves with people that we have identified as not quite of the standard of person we are—adults, upper middle class, more of the T.V. sitcom prototype.

Also, I would put in the groups that are being ignored, children with disabilities. We have child abuse councils in L.A. County that address the African-American community, the Latino community, the Asian-Pacific community. We've just started a child abuse council for the deaf community. We have a very strong task force looking at people with disabilities.

The picture that comes to most people's minds with child abuse is a dewy-eyed toddler or elementary school age child with a bruise on the face. It does not come to mind a child in a wheelchair that is receiving abuse and neglect from either family or professional care takers.

Mr. BALLENGER. Let me just say, you weren't in North Carolina at the time, and I don't know if they still have the coroner system in Georgia, but it took us 6 years of a heavy fight to do away with the coroner system consisting of mostly funeral directors. Everybody seemed to have a funeral director as your coroner, so we really didn't have a medical examiner system.

It took quite a fight to get all of them, and they are all politicians. I don't know how many funeral directors you have in the Georgia legislature, but we had quite a few in the North Carolina legislature. They were defending themselves to the death.

Ms. OLIVER. I think we have six.

[Laughter.]

Ms. OLIVER. The coroner is elected in the 159 counties of Georgia. The only qualification to serve is that they be 21 years old.

Mr. BALLENGER. Yes.

Ms. OLIVER. We have created a regional medical examiner system through the GBI, but the on-the-ground conflict between the old-time coroner and the modern GBI is being carried out. Part of our package was medical examiner legislation 2 years ago. It's a very tough political fight.

Mr. BALLENGER. Thank you, Mr. Chairman.

Chairman OWENS. Thank you for your patience. Your testimonies, of course, will be studied very closely. We may be in touch with additional questions. Thank you again for coming.

The subcommittee hearing now is adjourned.

[Whereupon, at 1:33 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

STATEMENT FOR THE RECORD

TO THE

HOUSE SELECT COMMITTEE ON SELECT EDUCATION

BY

JOYCE N. THOMAS, PRESIDENT
CENTER FOR CHILD PROTECTION AND FAMILY SUPPORT

March 16, 1992

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STATEMENT FOR THE RECORD PRESENTED TO THE HOUSE SELECT COMMITTEE ON EDUCATION

I would like to begin my statement by thanking Congressman Owens and other members of the House Select Committee on Education for extending this opportunity to me to provide input for the reauthorization of the Child Abuse Prevention and Treatment Act. My name is Joyce N. Thomas and I am President and co-founder of the Center for Child Protection and Family Support located on the Southeast side of the District of Columbia. The Center for Child Protection and Family Support is a non-profit agency which was established in 1987. The Center sets forth as its primary goal to address the critical needs of vulnerable children and their families. We seek to empower families, communities and the professionals through a variety of services which focus on critical issues in child welfare. We provide client-centered programs which includes an array of community-based activities for children and families. Our mission is to insure the healthy growth and development of all children but more specifically those disadvantaged children whom often have no voice in the social/ economic or political arenas.

In the wake of a growing number of issues which affect the families in this America, none has proved as damaging and even fatal to our children as child abuse and neglect. As had been documented by those who have testified before this House Select Committee on Education, as well as recent studies, there are more than two million children nationwide who have experienced brutal devastation and harm as the result of maltreatment. In addition, each year an estimated 2,000 children are known to have died as the result of such abuse or neglect (Family Violence 1990). Although the National Commission on Children reported that,"this is a good time to be a child," for the over two million children who will fall victim to child abuse or neglect each year - the time is not so good.

Despite the apparent concern for the welfare of our children, their future remains uncertain. Systems of care designed to serve the best interest of the child have failed to even define such interest, resulting in a nation of children abused and neglected by the very system of care which purports to protect them. In addition, due to disproportionate representation of children of color in such system who are three times more likely to spend an entire lifetime in care, large numbers of children of color become dependent on such systems. For them, the future is even more dismal because a process of protection, such as Child Protective Services, which fails to meet the needs of the "average child in care", is unable to meet the unique needs of children of color.

Many scholars indicate cultural, social and political factors which result in children of color being over reported such as discriminatory reporting practices, use of non-random samples, lower socioeconomic conditions among ethnic minority groups, and culturally different child-rearing practices among these groups. Furthermore, many studies indicate that these children and their families receive different service treatment than children from the dominant culture. Of particular concern are findings which indicate that children of color are more likely than white children to be removed from their families and that the type of care they receive is related to perceived potential according to race. These children are more likely to experience "foster care drift" (Close, JSW; Stehno,1982, VCPN 1986). If trends in proportional representation continue without simultaneous changes in service approaches for these populations, our system of protective service, which is already suffering severe stress, will no longer be able to function.

According to a recent study conducted by School of Social Work of the University of North Carolina, in 1980 the literature on decision-making in child abuse and neglect indicated that few states had developed systematic criteria for assessing child maltreatment. Professionals making these decisions exercised a high level of discretion and autonomy in decision-making (Lipsky,1980). Subsequent work on decision making indicated that worker decisions are inconsistent and are influenced by their background, experience and other factors (Stein,1984). Currently states are using risk assessment protocols in the assessment of abuse and neglect.

The purpose of this statement of record, is to make specific recommendations for modification in the language of the Child Abuse Prevention and Treatment Act that will spell out the states' responsibility for providing services in a culturally competent manner for all children. In addition, this statement is intended to provide some recommendations for strategies and approaches for assurance of a cultural competency system of care.

Given the large number of children and families who are cultural and ethnic minorities in the child abuse and neglect system (African-Americans, Hispanics, Native Americans, Asians), there is compelling justification for CAPTA to insure that states provide a culturally competent system of care. Thought many states have express a great deal of concern about this issue, it is time to move beyond words. As we seek to intervene more effectively in cases of child abuse and neglect. Consideration must be given to the diversity of different ethnic groups - family structural and dynamical differences as well as the differential influences on growth and development. This will provide the professional community with a culturally competent and specific model of care which can more affectively address the needs of children of color. Experts in the field have documented that by considering such differences will potentially improve the quality of decision-making and understanding, thus resulting in a more efficient and effective use of resources. Culturally competent workers are more likely to address the actual needs of the child and less likely to be blinded by their personal biases. A culturally competent system of care also insures that the agencies policies, procedures and regulations are consistent with the cultural dynamics of the population to be served.

Through direct experience and documentation in the literature, we know that a culturally competent system of care is one in which culture is accepted and embraced at all levels of care. This includes the evaluation of relationships within and across cultural lines, identification of the cultural differences and the effects such differences have on individual and family functioning, expanding our knowledge base and the modification of our models of service delivery to deal with culturally specific needs.

It is strongly recommended that states incorporate the issue of cultural competence at every level from intake and risk assessment to family preservation and termination of parental rights. Likewise, issues of cultural diversity should be considered by states when establishing child fatality teams - the development of which was outlined by others who have testified before the House Select Committee. Recent research has emphasized the importance of culturally competent approaches in service delivery as one way of maximizing service effects to minority populations. This framework emphasizes both the equity of services provided and the appropriateness of the efforts made to reunite families and their children. One underlying assumption is that services providers must understand the dynamics of minority families in order to make the most salient interventions (Williams,1989).

Using the April 25, 1988 PL 100-294 as a guide, we are recommending the following changes in the 1992 reauthorization:

pg.106 Section 6 (A) Research <to read> ...causes, prevention, identification, treatment and **cultural distinctions** of child abuse...

(B)...appropriate, effective and **culturally sensitive** investigative, administrative...

(C)(ii) child support, **cultural diversity**, handicaps and various other...

pg.109 Section 7 (C)
(1)
(B) to provide **culturally specific** instruction in methods of protecting children...
or
who work with **children of color** and handicaps...

* For the purpose of these proposed changes, "culture" is defined as the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. In other words, cultural competence is the state of being capable of functioning in the context of cultural differences. **"Children of color"** refers to the ethnic and cultural groups who are the focus of the People of Color Leadership Institute project. These include African-Americans, Asians/Pacific Islanders, Hispanics, and Native Americans.

IMPLEMENTATION STRATEGIES;

As we begin to even think about a more effective system of care for the prevention of child abuse and neglect in an effort to reduce the incidence of abuse and minimize the period of time children and families remain in care, policy makers, professionals, and other protective service workers must be open to understanding, respecting and valuing cultural differences.

Overcoming cultural ignorance which creates barriers to care for children and families of color necessitates the need for protective service workers to be mandated to learn how to express the information needed for the prevention of abuse and neglect in a manner which will empower various cultures of children and families to renew these efforts within their own cultural processes. At the same time, we must begin to draw upon members of these various cultures and experts in the field to inform us as to the diverse culturally specific client needs, obstacles to care and the various dynamics within their culture which effects interaction within the dominant culture.

As we begin to develop a culturally competent system, our major goal should be that access to the communities will be more opened, there will be fewer barriers to care and clients will become more responsive supportive services. Professionals will be better able to interpret behavior, provide more competent treatment, and more effective decisions with the best interest of the child in mind.

SYSTEMS ACCOUNTABILITY

Cultural competence as a model of service delivery encompasses the development of an entire system of care addressing cultural competency needs and issues on a number of different levels. In Protective Services, cultural competency is not merely a matter of definition or awareness on an academic level; failure to become culturally competent interferes with and often times invalidates

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the extent to which a worker can identify, act upon, and follow up on allegations of abuse. In addition, a lack of cultural competence grips the very ability of a system to effectively develop and actuate strategies of intervention and prevention of child abuse and neglect. For example, in the FRONTLINE documentary film, "Who Killed Adam Mann," it was obvious that the entire system of care was incapable of meeting the needs of this African-American family. The reunification approach was poorly understood, intervention strategies were narrow and insufficient, and agency policies for case management were problematic. Adam Mann's death was a result of both inadequate parenting and an inadequate system of care. Unfortunately only the parents were held accountable- the system will continued unchanged and more children such as Adam Mann will be potentially "at-risk" for in appropriate services.

Defining abuse and neglect is a critical issue, "one of central importance and logically precedes any discussion of incidence, etiology, or treatment" (Martin 1978). Unintelligible interpretations of culturally specific behaviors within families of color affects every facet of reporting incidence of abuse, developing treatment modalities and concepts, initiating data collection and research strategies, and conceptualization of policy and legislative efforts to combat abuse and neglect.

According to Jill Korbin, professionals in this field must learn to understand the "protective" factors verses the "exacerbating" factors within various groups families of color. Further, we must recognize the continuum of behaviors as well as the variabilities of responses to situations in our environment.

Work by Diane English of the University of Washington, indicates that there are several risk factors which have cultural implications. These include issues of adequate medical care, lack of supervision, levels of cooperation with authorities, parental skills and knowledge of child development, the child's role in the family and the parent child relationship. The lack of knowledge about various cultural differences on each of these decision making levels serves as a hinderance to effective service delivery and care of children of color. The fact that almost one-third of child-protection cases concern families or children of color with culturally determined child-rearing practices necessitate the need for a culturally competent system of care. Without such, the system of protection for these children is, in essence, a system of abuse and neglect- abuse of power and neglect of available resources by which one can become culturally competent.

In summary, the issue of developing a culturally competent system of care within the field of child abuse and neglect is one of assessment and systems improvement. As professionals, service providers and policy makers must evaluate their activities with the same honesty that is expected of the clients. The tendency to focus on individual clients' and families' deficits and pathologies by the system distorts an understanding of the causes and effects of child abuse and neglect.

HEARING OF US HOUSE OF REPRESENTATIVES SUBCOMMITTEE ON SELECT EDUCATION REGARDING NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

February 27, 1992

TESTIMONY OF JANIE D. FIELDS, EXECUTIVE DIRECTOR
CHILDREN'S TRUST FUND OF TEXAS COUNCIL

As executive director of the Children's Trust Fund of Texas Council, I appreciate the opportunity to present this testimony regarding the tragedy of child abuse and neglect in the United States.

The Children's Trust Fund of Texas and its nine-member governing Council were established by the Texas Legislature in 1985 to address the tragedy of child abuse and neglect by focusing on prevention. Prevention is an approach that is efficient and cost-effective in money, time, and energy and results in avoiding needless human suffering. Along with education and public awareness, prevention programs encourage all citizens to be advocates for children and youth.

In May 1991, the 72nd Texas Legislature approved legislation to establish CTF as a state agency with the official name: Children's Trust Fund of Texas Council. The primary purpose of the change to agency status was to establish a clear focus on prevention of child abuse and neglect in the State of Texas.

A future in which children are free of threats to their physical and emotional well-being is a vision shared by CTF and its funded programs and child advocates throughout the state. The common goal is to prevent child abuse and neglect by offering services which strengthen parents, children, and families.

WHAT IS PREVENTION?

Primary prevention services are available to the community at large or to families to keep child abuse and/or neglect from occurring. The key features of primary prevention are:

- offered to all members of a population and voluntary
- attempts to influence societal forces which have an impact on parents and children
- seeks to promote positive family functioning rather than to just prevent problems

Examples of primary prevention programs include, but are not limited to, educational programs in schools, parenting and prenatal educational and/or support classes, public awareness announcements, etc.

Secondary prevention is taking measures to keep child abuse and neglect from occurring after certain warning signals have appeared. The key features of secondary prevention are:

- offered to a pre-defined group of individuals at risk of child abuse and neglect and voluntary
- more focus on problems than primary prevention

- seeks to prevent future parenting problems by focusing on the particular stresses of identified parents or caretakers

Examples of secondary prevention programs include, but are not limited to, support programs for adolescent parents, programs for parents of infants or children with developmental problems, and programs for families with identifiable stresses.

Treatment programs, sometimes called tertiary prevention, are not within the mandate of the Children's Trust Fund of Texas. Such programs offer services to parents identified as having abused or neglected their children and services to the abused and neglected children.

Let me offer a few examples of the primary and secondary prevention program success stories since CTF began providing seed money for such community-based programs.

Recovering Parents was a designed as a pilot project for persons who had been in alcohol or drug addition recovery for at least six months and their spouses. It offered support and education in parenting and nurturing skills to these parents at risk of abuse and neglect. The success of this program was recognized locally and nationally with a volunteer of the year award for the coordinator. Since CTF funding ended, the program has continued under the auspices of the Texas Commission on Alcohol and Drug Abuse and has been promoted statewide.

Grandparents Outreach responds to the needs of parents and their latchkey children in the San Antonio area with a program staffed by senior volunteers and grandparents. Grandparents Outreach offers an example of the excellent community support which programs have received--Jack in the Box donated a van for the program to use in transporting the children from their schools to the Outreach centers. For her work, Grandparents Outreach founder and director Lou Ann Freas received President Bush's 350th "Daily Point of Light" commendation.

Project SHAPPE (Supporting Healthy and Positive Parental Efforts) is a program of the Association for Retarded Citizens in Austin. Its goal is to reduce the isolation experienced by mentally retarded and/or developmentally disabled parents and their children and to increase their exposure to healthy family relationships through the development of a curriculum to be offered statewide.

Growing Up in Arlington program provides a comprehensive education and awareness activities providing educational tools for parents and school personnel, equipping children with skills to prevent victimization and establishing support networks for children and families in the school and community.

Healthy Beginnings in Denton County assists low-income pregnant teens at risk of being inadequate or abusive parents. With the program established with CTF seed monies, a $250,000 federal grant was received for continuation of the program after CTF funding ends. The program's director stated that Denton County would not have received federal funding nor have a prenatal clinic had it not been for the initial investment by CTF.

Practical Parent Education programs in cooperation with the Texas Association of School Boards are providing services in five school districts in the

Rio Grande Valley--Hidalgo, La Feria, La Joya, Lyford, and Mission. With just $10,000 each or less, these programs have been able to use the available dollars effectively to serve a large number of families.

Another cooperative project, with the Texas Agricultural Extension Service, is Partners for Parenting. This program, active in almost all counties, strengthened families and reduced the risk of child abuse through parenting education and established a parenting curriculum library to be available through county extension agents. County agents served as facilitators for the parenting coalitions in their communities. Its parenting coalition services will be continuing with a grant from the Texas Department of Health.

The Assertive Parenting Program at Houston's SHAPE Community Center focused on black single parents to reduce the risk of child abuse. In a letter notifying CTF that the center could support the program in its third year without CTF funding, the board of directors said, "Because of your two years of support, we were able to educate parents, establish networks within the community, and build parent support groups. But most important of them all, we were able to have a positive impact on the consciousness toward child abuse and neglect within Houston's Third Ward."

A Prevention Program for Working Parents jointly sponsored by Texas Instruments and Dallas Community College provided parenting seminars during lunch hours and developed a companion curriculum. After just one year of funding, the program chose to be independent. Their letter stated, "We feel that the program is a success because of the start-up funds from the Children's Trust Fund."

Letters of gratitude from grantees and parents are positive feedback about programs, but CTF requires an extensive evaluation program focusing on defining and monitoring program performance to determine if a program is meeting its stated goals. Each grantee must include a performance evaluation component in its program. We are proud that the evaluation system we developed has been used as a model for other organizations and children's trust funds in other states.

We recognize the critical need for treatment services and dollars; however, if we had a substantial increase in prevention dollars, we would have both economic savings and future positive contributions from healthy children and families.

We are investing huge amounts of money to treat our problems. We are investing little to prevent them. The funding which NCANN provides enables us to have a significant impact on child abuse prevention in Texas. Simply put, we are talking about a program that works. In light of the impact that child abuse has on our society, I suggest that the $4.75 million for the Federal Challenge Grant is a minimum investment the federal government is making in trying to prevent this massive problem.

Few investments are ultimately more important in this country than investing in the lives of our children. Few investments in the lives of our children are paying higher ultimate dividends than investments in child abuse prevention programs through the Children's Trust Funds across this nation. I urge this Congress to act now -- without your leadership and vision the consequences and the social cost will continue to escalate.

The National Center on Child Abuse and Neglect is providing a vital network of assistance and resources that is filtering out into the hands of people who care and have the knowledge to prevent children's lives from shattering. It is more often impossible to put the fragments back together to form a healthy adult. Child abuse creates not just the lone tragedy of an individual life ruined, but the greater tragedy of other individuals--even society itself--victimized in its wake. That is why I recommend supporting the National Center on Child Abuse and Neglect because child abuse is indeed a national problem and preventing it is a national responsibility.

I appreciate the opportunity to present this testimony to this committee and wish you the best in your endeavors. I would be happy to answer any questions and can be contacted at my office 512/458-1281.

CHILDREN'S TRUST FUND OF TEXAS COUNCIL

MISSION

The Children's Trust Fund represents the commitment Texas has made to lead the way in setting policy and in offering resources to prevent child abuse and neglect. The Children's Trust Fund Council believes:

- Prevention of child abuse is crucial to the health of our society because it protects our most precious natural resource.
- Prevention comes from awareness of the existence and consequences of the problem, knowledge of how child abuse and neglect can be prevented, and understanding of what an individual can do to make a difference.
- Social attitudes and practices that tolerate and even promote violence toward children will change only when public and private sector prevention policies are established and prevention programs are implemented.

GOALS

The goal of the Children's Trust Fund of Texas is to reduce child abuse and neglect through funding assistance to community-level prevention programs in all areas of the State.

Major program objectives are to:

- develop public awareness
- enhance knowledge
- promote use of volunteers
- facilitate essential services and
- encourage development of public and private sector policies and programs to prevent child abuse and neglect.

Within these broad areas are long-range goals adopted by the Council:

- Parenting education--to ensure that all Texans have access to parenting education at the local level.
- Ethnic diversity--to support cultural traditions and strengths which foster positive child growth and development in an ethnically diverse state.
- Research--to promote cooperative research efforts that identify, assess, and evaluate approaches that enhance the capabilities of individuals to parent effectively.
- Advocacy--to provide information and recommendations to decision makers regarding policies which strengthen the support systems for children, youth, and families.
- Community prevention programs--to provide initial funding and technical assistance to programs which prevent abuse and neglect of children and youth.
- Collaboration--to engage communities, government, education, and

business support in collaborative efforts which enable all children to reach full potential.

36 PROGRAMS RECEIVE CTF SUPPORT

In fiscal year 1991, 36 child abuse and neglect prevention programs received Children's Trust Fund grants totaling $944,781 to provide services to Texas parents and children. In response to the requirement to obtain at least 20 percent of the grant amount in local cash or in-kind matching funds, approximately $408,000 in matching funds was provided by businesses, organizations, and individuals. The total amount of non-state dollars came very close to equaling the state dollar investment. In fiscal year 199[illegible]use of the 50% match required, the total of non-state dollars is expected to [illegible]d state dollars. Taken in total, these dollars are still minuscule in comparison to the dollars directed toward treatment services.

During the year, the programs reported services to almost 16,000 children and families. The hours contributed by volunteers are a critical component of program success. Volunteers donated 51,482 hours to the programs, representing a dollar value of $207,472, based on minimum wage.

The Children's Trust Fund commitment to collaborative efforts to prevent child abuse and neglect continued in fiscal year 1991. CTF awarded over $230,000 to support the activities of these cooperative demonstration projects. These efforts reached approximately 70,000 children and 51,000 families.

CTF-funded program activities have been enhanced by participation in the VISTA program (Volunteers in Service to America) in CTF programs. The use of these volunteers in local human service agencies strengthens programs, people, and communities in efforts to serve low-income families and children. This VISTA effort, the largest in Texas, has provided about 27 volunteers for 10 projects, as well as the CTF state office. In all sites, volunteers are stretching their capabilities, learning new skills, and supporting staff and agencies in their prevention efforts. To support these local prevention initiatives, the federal ACTION agency provides approximately $191,000 in annual stipends to the VISTAs.

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